



MEDICAL STAFF MEDICAL RECORD POLICY

ADULT AND PEDIATRIC H&Ps

Please refer to CaroMont Regional Medical Center Medical Staff Bylaws 12.E

History and Physical examination reports should include at a minimum, the following items: Chief Complaint/History of Present Illness, Past History, Review of Systems Physical Examination, Impression or Diagnosis, and Plan.

Short History and Physical forms may be used as approved by the appropriate Service Lines.

NEWBORN INFANTS

An admission physical examination shall be completed and recorded within twenty-four (24) hours after birth and the infant shall be examined daily during hospitalization. An infant may be discharged as long as he or she has been examined on that day and the discharge order is written. It is not necessary for the discharge summary to be complete if another note already exists on that day.

DOCUMENTATION FOR OUTPATIENT BLOOD TRANSFUSIONS AND IV MEDICATION INFUSIONS

For therapeutic outpatient blood transfusions and IV medication administration, the physician must provide an order for the treatment and the reason (diagnosis) for treatment.

OBSTETRICAL TRIAGE DOCUMENTATION

Patients seen in the Obstetrics Triage area with a stay less than 4 hours do not require a complete history and physical examination.

REQUIRED COMPONENTS OF THE MEDICAL RECORD

The medical record shall include information to support the patient's diagnosis and condition, justify the patient's care, treatment and services, and document the course and result of the patient's care, and services to promote continuity of care among providers. The components may consist of the following: identification data, history and physical examination, consultations, clinical laboratory findings, radiology reports,

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AW Rasmussen



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