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| MEDICAL RECORDS CHARTING PROCEDURES | | | | NO. 172D | |
| An active clinical record is maintained at the nurses station which contains:   1. Individual Service Plan 2. Admission   Forms properly filled in with current information.   1. History and Physical   Should contain copy of hospital and physical or discharge summary. A current history and physical is completed annually.   1. Physicians Orders   Orders should remain on chart for three (3) months. Telephone orders are to be recorded and attached to a page so orders are visible and accessible. They should be recorded consecutively according to the month.   1. Progress Notes   Should contain current progress notes from physician on 30 day basis.   1. Nurses Notes   Flow Sheets, if used, should precede Nurses notes for current month. At end of month, mark off remainder of sheet and begin new month on fresh progress notes sheet. This will allow you to glance at the charting as a whole.   1. Medication Sheet   These are to be maintained consecutively according to most current month on top.   1. Lab and Special Reports   Generally, current lab reports for last year to date.   1. Rehabilitation and Therapy 2. Reports for therapists for current year. 3. Social-activity reports for past 3 months. 4. Miscellaneous Record   Other current forms pertinent to resident care.  See Medical Record Instruction Manual | | | | | |
| Approved: | Effective  Date: | Revision Date:  3/17 | Change No.: | | Page:  1 of 1 |