

EMERGENCY DEPARTMENT POLICIES

| | | |
|-----------------|----------------------------|-----------------|
| SUBJECT: | Medical Record and Reports | NO. 13 |
| | | PAGE NO. 1 of 1 |

Original Date of Issue: 1/6/84

| | | | | | | | | |
|-----------|------|------|------|------|------|------|------|------|
| Reviewed: | 3/86 | 5/88 | 9/90 | 8/93 | 5/94 | 3/97 | 5/98 | 2/00 |
| Revised: | 6/91 | 2/96 | 8/99 | 7/01 | 5/03 | 4/06 | | |

Patient Population

| | |
|------------|---|
| Neonate | √ |
| Pediatric | √ |
| Adolescent | √ |
| Adult | √ |
| Geriatric | √ |

POLICY:

Every patient seen and treated in the Department of Emergency Medicine must have a chart either manual or electronic completed for that visit. Each record should contain the following:

1. Adequate patient identification, including demographic and insurance information.
2. Information concerning the time of the patient's arrival, means of arrival, and when appropriate by whom transported (i.e., 911-EMS)
3. Pertinent history of the injury or illness, including details relative to first aid or emergency care given to the patient prior to his arrival at the hospital.
4. A description of significant clinical, laboratory, and radiographical findings.
5. Diagnosis and treatment given.
6. The condition of the patient on discharge or transfer.
7. Final disposition, including instructions given to the patient and/or family, relative to necessary follow-up care.
8. Signature of the physician in attendance.

The IBEX record is defined as the medical record for the visit of any patient who leaves without treatment or left against medical advice; it will be maintained and accessible in the IBEX. All pertinent clinical information (i.e. any care was given. All medical records that become part of the chart are maintained by the Department of Medical Records.

Any demographical information for that patient is maintained and accessible in the Cerner system.