

3701-83-21 Medical records - ambulatory surgical facilities.

Each medical record required by paragraph (A) of rule 3701-83-11 of the Administrative Code shall contain at least the following information as applicable for the surgery to be performed:

- (A) Admission data:
 - (1) Name, address, date of birth, gender, and race or ethnicity;
 - (2) Date and time of admission; and
 - (3) Pre-operative diagnosis, which shall be recorded prior to or at the time of admission.
- (B) History and physical examination data:
 - (1) Personal medical history, including but not limited to allergies, current medications and past adverse drug reactions;
 - (2) Family medical history; and
 - (3) Physical examination.
- (C) Treatment data:
 - (1) Physician's, podiatrist's or dentist's orders;
 - (2) Physician's, podiatrist's or dentist's notes;
 - (3) Physician assistant's notes, if applicable;
 - (4) Nurse's notes;
 - (5) Medications;
 - (6) Temperature, pulse, and respiration;
 - (7) Any special examination or report, including but not limited to, x-ray, laboratory, or pathology reports;
 - (8) Signed informed consent form;
 - (9) Evidence of advanced directives and do-not-resuscitate orders, if applicable;
 - (10) Operative record;
 - (11) Anesthesia record, if applicable; and
 - (12) Consultation record, if applicable.
- (D) Discharge data:
 - (1) Final diagnosis;

- (2) Procedures and surgeries performed;
 - (3) Condition upon discharge;
 - (4) Post-treatment care and instructions; and
 - (5) Attending physician's, podiatrist's or dentist's signature.
- (E) Other information required by law.

Effective: 07/01/2016

Five Year Review (FYR) Dates: 02/16/2016 and 02/15/2021

CERTIFIED ELECTRONICALLY

Certification

04/22/2016

Date

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