

3701-84-73      **Medical record.**

In addition to the requirements of rule 3701-84-11 of the Administrative Code, each radiation therapy service and/or stereotactic radiosurgery service shall maintain documentation of the following in the patient's medical record:

- (A) Confirmation of the presence of malignancy by histopathology, a statement of benign condition, or other alternative evidence for diagnosis of all cases accepted for radiation;
- (B) Documentation of services and radiographic images, including localization films, appropriate to the therapy provided;
- (C) Report of the initial evaluation including a definition of the tumor or target type, location and the extent of each cancer as a basis for staging;
- (D) The treatment plan including the selection of dose, selection of treatment modality, and selection of treatment technique;
- (E) The dosimetry calculations;
- (F) The patient's progress and tolerance; and
- (G) The completion of treatment with statement of a follow-up plan.

R.C. 119.032 review dates      05/11/2012 and 05/01/2017

CERTIFIED ELECTRONICALLY

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Certification

05/11/2012

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Date

Promulgated Under:      119.03  
Statutory Authority:      3702.11, 3702.13  
Rule Amplifies:      3702.11, 3702.12, 3702.13, 3702.14, 3702.141,  
   3702.15, 3702.16, 3702.18, 3702.19, 3702.20  
Prior Effective Dates:      3/1/1997, 3/24/03, 5/15/08