

4640.1000 MEDICAL RECORDS.

Subpart 1. **Personnel.** A trained medical record librarian or other authorized hospital employee shall be given the responsibility for the proper custody, supervision, indexing, and filing of the completed medical records of patients.

Subp. 2. **Facilities and equipment.** Space and equipment shall be provided for the recording and completion of the record by the physician as well as for indexing, filing, and safe storage of medical records.

Subp. 3. **Information to be included.** Accurate and complete medical records shall be maintained on all patients from the time of admission to the time of discharge. The following additional information shall be obtained and recorded for all maternity patients: full and true name of patient and her husband, the place of residence of the patient prior to hospitalization, and place of residence following discharge. To be considered complete, a record should include:

- A. adequate identification data;
- B. admitting diagnosis, to be completed within 24 to 48 hours;
- C. history and physical examination, including history of pregnancy on maternity cases, to be completed within 24 to 48 hours;
- D. progress notes;
- E. signed doctors' orders;
- F. operative notes, where applicable to include course of delivery on maternity cases;
- G. special reports and examinations, including clinical and laboratory findings, X-ray findings, records of consultations, anesthesia reports, etc.;
- H. nurses' notes;
- I. discharge diagnosis; and
- J. autopsy report, where applicable.

Subp. 4. **Records on newborn infants.** A medical record shall be maintained on all newborn infants and shall include a physical examination performed and recorded by the physician and a statement relative to the physical condition of the infant at the time of discharge. When the child leaves the hospital with any person other than a parent, the hospital shall obtain and record the true name of the person or persons with whom the child leaves, and the place of residence where it is planned that the child is to be taken.

Subp. 5. **Completion of the record.** The medical staff shall have a policy requiring that the medical records shall be completed within a reasonable time following the discharge

of the patient. The completion of the medical record shall be the responsibility of the attending physician.

Subp. 6. **Surgical cases.** The history and physical examination record shall be completed and signed by the attending staff member prior to the performance of any surgery except in case of emergency when an admission note including significant findings and diagnosis shall be written.

Statutory Authority: *MS s 144.55; 144.56*

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