



Medical Records

APPROVED BY COUNCIL:	November 2000
REVIEWED AND UPDATED:	September 2005
PUBLICATION DATE:	March/April 2006
TO BE REVIEWED BY:	September 2010
KEY WORDS:	Records, Charts, Documentation
RELATED TOPICS:	Confidentiality, Mandatory Reporting, Consent to Medical Treatment, Third Party Reports
LEGISLATIVE REFERENCES:	<i>Regulated Health Professions Act, 1991, S.O. 1991, c. 18, as amended; Ontario Regulations 856/93 and 241/94, as amended (made under the <i>Medicine Act, 1991</i>); <i>Health Insurance Act, R.S.O. 1990, c. H.6; Independent Health Facilities Act, R.S.O. 1990, c. 1.3; Mental Health Act, R.S.O. 1990, c. M.7; Personal Health Information Protection Act, 2004, S.O. 2004, c.3, Sched. A; Public Hospitals Act, R.S.O. 1990, c.P.40; Long-Term Care Act, 1994, S.O. 1994, c. 26; Health Care Consent Act, 1996, S.O. 1996, c.2, Sched A; Children's Law Reform Act, R.S.O. 1990, c. 12; Limitations Act, 2002, S.O. 2002, c. 24, Sched. B</i></i>
COLLEGE CONTACT:	Physician Advisory Service

Medical Records

INTRODUCTION AND SCOPE

This policy sets out the essentials of maintaining medical records. Designed primarily to apply to records created for office and long-term care environments, it offers guidance with respect to the principles and requirements for all medical records.

For advice with respect to hospital-based records, see the guide developed by the Physician Documentation Expert Panel, in which the College participated. http://www.health.gov.on.ca/transformation/providers/information/im_exppanel.html

PRINCIPLES

Good medical record keeping is part of providing the best quality of medical care.

Physicians are obligated to make records for each of their patients. The primary use of these records is for the treating physician and other health care professionals to ascertain the patient's medical history and identify problems or patterns that may help determine the course of health care that should follow. In addition, good records can help optimize the use of resources, both financial and human, by reducing duplication of services and, sometimes, by identifying abuse of the health care system. They may also provide information essential to others for a wide variety of purposes: billing; research; and response to public complaints, legal proceedings or insurance claims, for example.

Some of the elements of the guidance provided below are mandatory: either required by law, or expected by the College as a minimum practice standard. Wherever this is the case, the policy will explicitly indicate that adherence is obligatory. In some cases, the obligations do not arise from medical practice standards but from Ontario Health Insurance Plan (OHIP) requirements:¹ such instances are identified in the text. Other components of the policy are offered as recommendations as to the best means of providing patients with quality medical care. These references have been included to provide physicians with as much information about record keeping as possible, but are not College requirements for medical record keeping. The ultimate objec-

tive of the policy is to set out what must be kept in medical records and to provide physicians with a tool that will permit them to maintain a record keeping system that is functional, practical and easy to maintain.

1. THE IMPORTANCE OF GOOD RECORD KEEPING

Continuity and Quality in Medical Care

The medical record must “tell the story” of the patient as determined by the physician in the circumstances in which he or she saw the patient. The components necessary to tell the story are set out in detail below. The record is not just a personal memory aid for the individual physician who creates it. It must allow other health care providers to read quickly and understand the patient's past and current health concerns. It is not expected, however, that all patients will always be able to read and understand their medical records. Medical records may contain abbreviations and terminology unique to the health care professions.

Comply with all Legal Requirements

The medical record is a legal document which records events and decisions that help physicians manage patient care. A physician following the recommendations in this policy will be in compliance with the record keeping requirements of the College and requirements set out in the Ontario Regulations made under the *Medicine Act* (referred to in this policy as the “regulation”).² The regulation is included at Appendix A.

Many physicians are also associated with institutions or facilities that may have their own record keeping requirements. Physicians to whom this applies should investigate and be familiar with those legal obligations that may arise in the *Public Hospitals Act*, the *Long-Term Care Act*, or the *Independent Health Facilities Act*.

Other legislation, such as the *Mental Health Act* and the *Personal Health Information Protection Act (PHIPA)*³ also has an impact on medical records, either on what is in them or to whom they may be transferred. These will be referred to in more detail in the applicable sections below.

¹ Note: At the time of writing, a new OHIP audit process is under development by government and has not yet been finalized.

² O. Reg. 114/94, as amended, s.18.

³ If a physician is engaged in work that would be considered a “federal work or undertaking” the federal privacy legislation (the *Personal Information Protection and Electronic Documents Act*) may apply.



Records and External Reviews

Medical records are fundamental components of regulatory reviews, such as those conducted for quality improvement purposes (CPSO's Peer Assessment Program and Independent Health Facilities Program), or investigative purposes (such as inquiries made by the Coroner's Office, CPSO investigations) or billing reviews.

A medical record may provide significant evidence in lawsuits, hearings or inquests.

Regardless of the type of assessment or investigation, a good or bad medical record may have a significant positive or negative effect on the outcome of the process.

A physician may assess his or her own medical record keeping practices, by answering the questions listed in Appendix B, which have been taken directly from a protocol used in the CPSO's peer assessment activities.

OHIP Documentation Requirements

OHIP and Ministry of Health and Long-Term Care (MOHLTC) requirements may change over time and physicians should stay abreast of any changes through OHIP and Ontario Medical Association (OMA) information sources.

Physicians must understand their obligations under the *Health Insurance Act* and the OHIP Schedule of Benefits. Section 37.1 of the *Health Insurance Act*, which deals with record keeping, is attached as Appendix C.

Good records demonstrate that a service was provided to the patient and establish that the service provided was medically necessary. It is, therefore, imperative that physicians maintain accurate and comprehensive records, in order to receive payment for their services.

Any questions that physicians may have regarding the OHIP Schedule of Benefits should be directed to the appropriate local branch of OHIP or the Provider Services Branch of the MOHLTC, as listed in Appendix D.

2. OVERVIEW AND ORGANIZATION OF MEDICAL RECORDS

The Daily Diary of Appointments

Maintaining a daily diary of patient appointments is required by the regulation⁴ and must include all professional encounters.

While some physicians use the diary only to list the patients seen each day, the daily diary can also contain other useful information, such as the patient file and OHIP number, the patient complaint or health problem, and information related to the complaint or problem. Recording information relating to the patient complaint or problem will facilitate the task of billing OHIP.

Chronological and Systematic

It is strongly recommended that all materials in the patient chart be organized in a chronological and systematic manner.

Timing of the Events

All patient-related documentation must be dated. Consultation reports, laboratory and diagnostic results must be manually or electronically initialed and dated when they are reviewed. Every patient encounter must be documented and dated in the medical record.

Where there will be more than one physician making entries in a record, each physician's entry must be identified by signature and, if appropriate, position or title. The *Health Insurance Act* (relevant excerpts of which can be found at Appendix C) requires that physicians record the start and stop time for certain types of patient encounters, such as psychotherapy and counselling. In addition to these, it is prudent for physicians to record the start and stop times for some other types of clinical encounters, such as procedures in the ER, resuscitation, administration of medications, and telephone conversations.

The College recommends that entries be recorded as closely as possible to the time of the encounter, when the detail is most fresh in the physician's mind. This will allow physicians to keep records that are detailed, accurate and comprehensive.

⁴ O. Reg. 114/94 section 18(2): A member shall keep a day book, daily diary or appointment record containing the name of each patient who is encountered professionally or treated or for whom a professional service is rendered by the member.

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Removing Portions of the Record

Sometimes storage requirements may necessitate the removal of some materials from a patient's active chart. If investigation results and consultation reports are no longer relevant to the patient's current care, it is permissible to store them elsewhere (in accordance with the retention requirements set out in the regulation, see below for further detail). In such instances, the physician should make a notation indicating that documents have been removed from the chart and the location where they have been stored.

Clarity and Legibility

The regulation requires that medical records be legible.⁵ Furthermore, the College expects that the records can be interpreted by the average health care professional. If there is difficulty with the legibility of the records, an alternate means of note taking should be considered (e.g., voice dictation, electronic medical records, or handwriting recognition software).

Using conventional medical short forms is permissible. However, the meaning should be readily available to a health care professional reading the record.

Modifying Records

Sometimes it is necessary to modify medical records. Where necessary to ensure accuracy of the medical record, it is permissible to do so. Corrections must be made in such a manner as to ensure that the correct information is recorded (with the additions or changes dated and initialed) and the incorrect information is either severed from the record and stored separately, or maintained in the record but clearly labeled as being incorrect. Where the incorrect information is severed from the record, physicians must ensure that there is a notation in the record that allows for the incorrect information to be traced. Where incorrect information is maintained in the record, physicians must ensure that the information remains legible.

PHIPA also stipulates that physicians must make corrections requested by patients, if the patient shows

that the record is incomplete or inaccurate.⁶ If the physician is not persuaded that a correction requested by a patient is warranted, the patient may require the physician to attach a statement of the patient's disagreement to the medical record. The statement of disagreement would then become a part of the record.⁷

Where physicians are uncertain as to how to properly correct information, the College's Physician Advisory Service may be a helpful resource. In addition, physicians may wish to consult their lawyer or the Canadian Medical Protective Association (CMPA), as deliberately altering the medical record may be considered professional misconduct.

Storage and Security

Medical records must be stored in a safe and secure environment to safeguard their physical integrity and confidentiality. Physicians must take reasonable steps to ensure that records are protected from theft, loss and unauthorized use or disclosure, including photocopying, modification or disposal.

What is reasonable depends on the threats, risks and vulnerabilities to which the information is exposed, the sensitivity of the information, and the extent to which it can be linked to an identifiable individual. Consideration must be given to each of the following aspects of record protection:

- Physical security (for example, locked file cabinets, restricted office access, alarm systems).
- Technological security (for example, passwords, encryption and firewalls).
- Administrative controls (for example, security clearances, access restrictions, staff training and confidentiality agreements).⁸

Patient records should be kept in restricted access areas or locked filing cabinets, and measures should be in place to ensure that only those who need access to the records for a legitimate purpose are able to see them. Physicians need to consider that non-medical

⁵ O. Reg. 114/94 section 18(3): "The records required by regulation shall be, (a) legibly written or typewritten or made and kept in accordance with section 20...." (i.e., electronically).

⁶ *PHIPA*, ss 55(8).

⁷ *PHIPA*, ss 55(11).

⁸ If personal health information is stolen, *PHIPA* requires that the physician notify the patient. Some exceptions apply.



staff, such as maintenance staff, may have access to records, and must ensure that steps are taken to ensure that access to the records is limited or that those who have access to the records are bound by an appropriate confidentiality agreement.

Electronic Records

All of the principles discussed in this policy apply equally to electronic records. The records must contain the story of the patient. While there is some debate about the preferred format of electronic records (e.g., template-based records vs. voice dictation-based records), an electronic format will be adequate if it can capture all the pertinent personal health information and allows the user to centralize the essentials of the patient's story on several screens. If the format cannot do this, it is probably not satisfactory and the physician should consider using an alternative system.

The College recognizes some limitations of electronic records at the time of writing this policy. In many cases, the printable version of the electronic record does not readily enable a reviewer to understand the whole patient record and is, therefore, of limited use. Furthermore, some of the systems do not readily allow the physician to capture nuances of the patient encounter. Physicians using such systems must ensure that each record entry captures the unique aspects of that particular patient encounter. The College is aware that this is a developing area and that there is great potential for electronic record keeping to enhance the practice of medicine.

Physicians have an obligation to provide printed copies of electronic records when asked to do so. In order to ensure they can be understood, some physicians provide the print-out from the electronic record together with a dictated summary to provide an overview of the patient's story.

Specific requirements for physicians who maintain electronic patient records are set out in sections 18-21 of Ontario Regulation 114/94, listed in Appendix A.

The College notes that residents frequently retain patient information on PDAs and laptops in order to track workload and for educational purposes. Issues about storage, deletion of records and privacy of

health information can pose the same problems in this context as discussed elsewhere in this policy, and those who are using records in this fashion are cautioned to ensure that they are doing so in adherence to the policy.

Record Storage

Copying patient records is easy and inexpensive in electronic form. It is essential that a physician be aware of the number of copies of his or her records that are created and ensure that only as many copies are maintained as are required for system security. For example, many physicians will rely on systems in which a central server is used for storage. The physician must ensure that the privacy of patient records will be adequately protected whether the information is stored in premises within the physician's control or otherwise. Physicians must discuss how records can be expunged or protected by the service provider before entering into a contract for the provision of the service. In order to protect patient privacy, when the physician ceases to use that storage system, he or she should ensure that no copy is left with the server. If the information is stored on the computer's hard drive, the hard drive itself should either be crushed or wiped clean with a commercial disk wiping utility. Similarly, any back-up copies of medical records should be destroyed when the original records are destroyed.

Security

Physicians need to be aware that e-mails and web servers are not secure. Physicians should not send personal health information by e-mail without express consent to do so from the patient. Service providers such as Rogers or Sympatico do not provide secure e-mail systems. Web-enabled e-mail, such as Hotmail, is completely unsecured. There are systems that provide an acceptable level of security; those physicians who wish to send personal health information by e-mail should use an encrypted or otherwise secure system.

Wireless Internet access causes other security concerns. If physicians are using such a system, it is highly possible that others in the vicinity can "eavesdrop" on the information being accessed. Document and system password protection can delay or prevent unauthorized access but physicians using wireless Internet must be sensitive to the security issues.

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All hard drives fail eventually. It is mandatory for physicians using electronic records to ensure that they are using an effective back-up system that is updated frequently. Furthermore, an off-site back-up system is highly recommended (for example, a CD or other mass storage device). This will protect patient records in the event that the physician's computer or office has been destroyed.

While electronic records offer opportunities to enhance patient privacy (by restricting office staff access in a way that is impossible in an office using paper records, for example), they may also be vulnerable to intrusion. Physicians should document protocols about who in their office has access to which records and should ensure that the system being used restricts access to those entitled to access. This would apply even more acutely to physicians using systems that allow them to share records with hospitals and other care facilities. In such circumstances, it is essential that physicians ensure that adequate security measures are in place.

A physician is more likely to take his or her laptop out of the office than all of his or her paper records. For physicians who take records out of the office or access their electronic records from a location other than their own office, it is imperative that they take the appropriate measures to restrict access and maintain the privacy of patients' personal health information.⁹

Networking

One advantage electronic records have to offer is simple and fast electronic transmission of test results and other documents between health care providers or facilities. At the time of writing, electronic systems are not sufficiently sophisticated to manage such transactions. This development is anticipated. In the interim, a physician may not rely on electronic communications of this type unless he or she has taken reasonable steps to ensure that documents sent are received.

Transfer from Paper to Electronic Records

When a physician scans his or her paper records to convert them to electronic form, the original paper

records may be destroyed in accordance with the principles set out in this policy.

3. GENERAL PRINCIPLES FOR CONTENTS OF MEDICAL RECORDS

A medical record is an essential tool in providing continuity of care for all patients, regardless of the nature of the relationship between the physician and patient, and/or the frequency of patient encounters. As stated above, the record must tell the story of the patient's health care condition and should allow other health care providers to quickly read and understand the patient's health concerns or problems.

Each record of a patient encounter, whether in a clinic or at the patient's home, must include a focused relevant history, appropriate focused physical exam (when indicated), a provisional diagnosis (where indicated) and a treatment plan.

Communicating with Patients

The first step in taking a patient's medical history is to clarify and verify the patient's reason for the visit. The physician should be mindful that nonverbal communication such as tone of voice, mannerisms and 'body language' may give important clues as to the patient's underlying problem and concerns.

The College would expect a physician not to make derogatory or inappropriate comments about a patient in the record.

Collection of Information Indirectly

Physicians should, unless *PHIPA* provides otherwise, always obtain the patient's consent when collecting, using or disclosing personal health information.

Physicians are permitted to collect information indirectly without consent in the instances set out in section 36 of *PHIPA*. One example is where the information is reasonably necessary for providing health care or assisting in providing health care to the individual, and it is not reasonably possible to collect, in a timely manner, personal health information directly from the individual or personal health information that can reasonably be relied on as accurate.

⁹ An example of the risk to patient confidentiality that can arise through the use of electronic records occurred when a medical transcriptionist typed doctors' medical reports on her home computer. She experienced problems with the computer's hard drive and returned it to the store where it had been purchased. The store assured her that the information on the hard drive would be deleted, but the computer was resold with the information intact. The purchaser discovered the medical records and took the matter to a local TV station.



Communicating with Other Health Care Providers

The need for good communication also applies between health professionals. Multidisciplinary care is a fact of life in our health care system and the medical record serves as the conduit of information shared between health care providers. Continuity of care can only be preserved if the flow of information remains uninterrupted and intact.

The Cumulative Patient Profile (CPP)

In most settings, each patient's chart should contain a brief summary of essential information about the patient. This "snapshot" of the patient includes critical elements of the patient's medical history, allowing the treating physician, or any other health care professional using the chart, to quickly get the picture of the patient's overall health.

A CPP is an example of a very effective summary, such as that described above. Proper use of a CPP will save the physician time by reducing the need to rewrite information in the progress notes when the information is already contained in the CPP.

A complete CPP containing current information can help to prevent errors and duplication of documentation. Appendix E contains sample CPP forms, which each physician is encouraged to customize to meet his or her needs.

Ideally, the information in a CPP would include:

- Patient identification (name, address, phone number, OHIP number)
- Personal and family data (occupation, life events, habits, family medical history)
- Past medical history (past serious illnesses, operations, accidents, genetic history)
- Risk factors
- Allergies and drug reactions
- Ongoing health conditions (problems, diagnoses, date of onset)
- Health maintenance (annual exams, immunizations, disease surveillance, e.g., mammogram, colonoscopy, bone density)

- Consultant's names
- Long-term treatment (current medication, dosage, frequency)
- Major investigations
- Date the CPP was last updated
- Contact person in case of emergencies

Making the CPP Work

The CPP should be completed during the first or second patient encounter, and placed at the front of the patient's chart for easy access and reference. However, there is no reason not to commence keeping a CPP for all patients in an existing practice, even where this has not been done before.

It is important for physicians to review the information in the CPP regularly and to revise this information as it becomes outdated. Regular review and revision is particularly important where physicians are required to send the information to third parties such as medical consultants, the hospital emergency room, lawyers, and insurance companies. In these situations, physicians must ensure they are providing these parties with accurate and current information.

The CPP can be used as a quick and easy way for office staff to access important data such as immunizations.

Physicians can supply patients with their CPP when they travel or are referred to another health care professional.

A comprehensive CPP will be valuable in cases where physicians are required to produce printed copies of electronic records. The CPP will provide a useful overview that will help the reader interpret the sometimes cumbersome or confusing print version of an electronic record.

Progress Notes

Progress notes are notes that are made contemporaneously with a physician patient encounter.

One of the most widely recommended methods for documenting a particular patient encounter is the Subjective Objective Assessment Plan (SOAP) format.

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This format is widely used in medical practices and most medical office software uses a SOAP format for documenting patient encounters.

The advantages are many and include encouraging comprehensive records, reducing unnecessary documentation, assisting in the organization of the note, saving time, and facilitating rapid and easy retrieval of information from the record.

Physicians should consider the following points when documenting their patient encounters:

Subjective Data

- Presenting complaint, including the severity and duration of symptoms;
- Whether this is a new concern or an ongoing/recurring problem;
- Changes in the patient's progress or health status since the last visit;
- Past medical history of the patient and his or her family, where relevant to the presenting problem;
- Salient negative responses.

Objective Data

- Relevant vital signs;
- Physical examination appropriate to the presenting complaint;
- Positive physical findings;
- Significant negative physical findings as they relate to the problem.

Assessment

- Patient risk factors, if appropriate;
- Ongoing/recurring health concerns, if appropriate;
- Review of medications, if appropriate;
- Review of laboratory and procedure results, if available;
- Review of consultation reports, if available;
- Diagnosis, differential diagnosis, or problem statement in order of probability and reflective of the presenting complaint.

Plan

- Discussion of treatment options;
- Tests or procedures ordered and explanation of significant complications, if relevant;
- Consultation requests including the reason for the referral, if relevant;
- New medications ordered and/or prescription repeats including dosage, frequency, duration and an explanation of potentially serious adverse effects;
- Any other patient advice or patient education (e.g., diet or exercise instructions, contraceptive advice);
- Follow-up and future considerations;
- Specific concerns regarding the patient including patient refusal to comply with your suggestions.

4. RECORD KEEPING FOR SPECIFIC TYPES OF ENCOUNTERS

Medical records must meet expectations for three different types of external review: quality assurance, legal, and auditing. A good record will provide enough information to satisfy inquiries made by any of these bodies. The following specific examples of information to be included in records of particular types of encounters may assist physicians in understanding what is required to ensure that their records are sufficient for all purposes.

The Periodic or Annual Health Examination

Primary health care providers conduct periodic (or annual) health examinations for health maintenance and disease screening. The difference between these examinations and the more frequent physician/patient encounter is that these examinations are more comprehensive. This must be reflected in the medical record.

This type of encounter should be recorded as a periodic health exam. It is advisable to use the CPP to review and update the patient's medical history, family and social history, ongoing health concerns or problem list, immunizations, allergies, and medications. (The purpose of taking the family and social history is to generate a risk profile for diseases based on age,



gender, family history, and occupation. The risk profile serves to direct further history-taking, the physical examination and screening tests, as well as necessary patient education and health promotion). The record should show evidence that appropriate screening and preventive care is taking place as the patient progresses through his or her life.

The physical examination should include all body parts and systems appropriate to the age and gender of the patient.

The treatment plan, if any, including tests or procedures ordered and any advice given, should also be documented.

Discussion of treatment options, explanation of significant complications and potentially serious adverse effects of medications should also be included in the chart, along with referrals to other health care professionals, where applicable.

General Assessments

The general assessment is a comprehensive examination conducted to establish a diagnosis, ascertain target organ involvement, and develop an investigative and treatment plan for a specific medical condition. The physical examination should include all body parts and systems relevant to the condition at issue (e.g., if the presenting problem is chest pain, the physician would examine the body parts that might be involved, but might not conduct a pelvic or rectal examination).¹⁰

This type of encounter should be recorded as a general assessment. Again, the CPP should be used to review and update the patient's medical history, family and social history, ongoing health concerns or problem list, immunizations, allergies, and medications. The record of the visit should reflect all of the elements of the physical examination.

Patients with Chronic Conditions

For patients with chronic conditions, such as diabetes mellitus, it is often useful to have flow sheets that allow the physician to record important clinical information about the patient's management over long

periods of time. Flow sheets permit the physician to see trends that enhance his or her ability to identify the appropriate treatment. Flow sheets will, of necessity, deal only with one disease. The CPP and the progress notes will be the principal information used to ensure comprehensive care.

Two sample diabetes mellitus flow sheets are included in Appendix F.

Patient Encounters where Focus is Psychotherapy

Psychotherapy is any form of treatment for mental illness, behavioural maladaptations or other problems that are thought to be of a psychological nature or to have an emotional component. The same legal requirements apply to records maintained for psychotherapy as to other sorts of records. Maintaining records that "tell the patient's story" is particularly crucial in the psychotherapeutic context because there may be less objective physical data upon which to base treatment plans.

The following are the minimum components of a complete psychotherapeutic record:

- History;
- Mental status;
- Diagnosis and assessment;
- Treatment plan (medications, treatment methodology, etc.);
- Progress notes/follow-up visits (which, in the psychotherapeutic context, should include the physician's input and also information regarding the patient's response);
- Outcome assessment (at the end of the treatment period);
- Termination note (which describes the patient's reaction to the conclusion of the doctor-patient relationship).

SOAP Documentation for Psychotherapy

The SOAP record keeping format may be easily adapted to gather and document information obtained during psychotherapeutic sessions.

¹⁰ There will be occasions when specialists are conducting condition-specific examinations that include all the components necessary to assess the patient's condition but do not include all the aspects of a general assessment. In these circumstances, the specialist should seek the appropriate assessment code to bill for the encounter.

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The College recommends that physicians use the SOAP format but recognizes that other systems are acceptable as long as they capture all of the information stipulated above.

Subjective

- Initial visit: problem statement, duration, relevant background history, evolution of the problem, and present status;
- Follow-up visits (progress notes): development since last visit, response to therapy.

Objective

- Exploration of the biopsychosocial axis (such as the effects of physical symptomatology on the patient's personal life, family life, work and relationships);
- Mental status (may not be noted in a particular progress note if there is no change).

Assessment

- Diagnosis (may not be noted in a particular progress note if there is no change);
- Summation of issues/physician's input (for example, even though the physician has been silent throughout the session he or she may record an analysis of the patient's ongoing issue).

Plan

- Therapeutic goals/plans;
- Types of psychotherapeutic approaches/models; for example, psycho-dynamic (insight oriented), behavioural modification, cognitive therapy (whether supportive or instructional);
- Medications;
- Referral details.

Counselling

Individual counselling is a medical encounter that is an educational dialogue for the purpose of developing patient awareness of the problem or situation.

The following information should be included when documenting a counselling session:

- Subject being discussed;
- Scope of the discussion (educational components, treatment options, prognosis, etc.);
- Patient's response to the discussion;

- Therapy prescribed (if any);
- Action plan or goal including follow-up.

The physician will want to remember that for OHIP billing purposes counselling appointments require documentation of the start and stop times and are limited to a certain number of blocks per year.

Record Keeping for Couples and Family Therapy

When treating individuals together, the records must reflect information about each individual and also about the relationship.

Where individuals are treated together, either in couples or family therapy, the personal health information of the individuals is shared and communicated in a group setting. Since these individuals choose to share their personal health information in the context of couples or family therapy (or other group therapy) the physician does not have to make efforts to protect the privacy of these individuals in relation to the personal health information that they share. Where the individuals receive a combination of individual and group therapy, physicians must protect personal health information that is disclosed during individual therapy, as this information is most likely disclosed only for the purpose of individual treatment. In these situations, the College suggests that physicians keep separate records for individual therapy and for group therapy.

Third parties, such as mediators, lawyers or Courts may request records of couples or family therapy. Consent will be required from all of the individuals involved in the therapy and the consent will need to be specific to the material chosen or the reports given. Disclosure of personal health information to third parties is discussed in the section entitled 'Confidentiality' on page 14. For further information, physicians should consult the College's Confidentiality of Personal Health Information policy.



5. PROCEDURAL MEDICINE

Recording Specific Elements of the Encounter

Consultation Requests

Consultation requests should include:

- Reasons for referral;
- Urgency of the consultation;
- Relevant medical history;
- Current medications;
- All relevant test and procedure results.

For billing purposes, it is not necessary for the referring physician to retain a copy of the referral note but the College recommends that he or she do so – both in order to maintain a record of the date and nature of the referral and as part of the ongoing record of the patient's story.

Consultants' Records

A consultant's records should follow the same guidelines as those outlined above under the heading "Progress Notes." In addition, the consultant should ensure that the record indicates who is the most responsible physician for the purposes of providing follow-up or ongoing care.

Patient Non-Compliance or Failure to Attend Appointment

Physicians should document all instances of a patient refusing an examination. Most physicians have had an experience where a patient has refused to have an examination or a specific portion of an examination, or asked to defer the examination to a later date. It is essential that physicians document all advice, tests or treatments that are refused or deferred by the patient to ensure that anyone who reads the medical record will receive an accurate depiction of the treatment that the patient has received, and will gain an understanding of the treatment decisions the patient has made.

Where treatment has been refused or deferred, the medical record should also indicate the reason, if any, given by the patient for declining the advice and treatment recommendations of the physician, as this information may be important for the future care of the patient.

The medical record should also note when a scheduled appointment is missed by a patient.

Telephone Conversations and E-Mails

Ideally, all telephone calls would be recorded in the patient's chart. It is strongly recommended that telephone calls dealing with matters of significant clinical impact that are made to or received from the patient be documented. The documentation should include the date and time of the call, significant information and advice provided. Records should also indicate any prescriptions or repeats authorized over the telephone. The CMPA emphasizes the importance of documenting phone calls as evidenced by its development of a "Patient Telephone Call Record," available free-of-charge to members. This note-sized sheet has a self-adhesive portion that allows the physician to affix the completed note into the patient's medical record.

There are a few good reasons for including phone calls in the medical record because they:

- Will assist in providing better continuity of care;
- Could provide significant evidence in lawsuits, hearings or inquests when provision of patient care might be in question;
- Serve as fundamental components of external reviews relating to quality of care, and inquiries such as those made by the Coroner's Office, etc.

Records of e-mails to and from patients should be treated in the same way as records of telephone calls. Where possible, it is advisable to copy all correspondence for the chart, particularly those dealing with matters of significant clinical impact.

6. RETAINING AND TRANSFERRING MEDICAL RECORDS

Generally speaking, physicians must always keep the original medical record themselves. Only copies of the record should be transferred to others.

Retaining Medical Records

Regulation requires that physicians keep medical records for a certain period of time. For adult patients, the rule is that records must be retained for 10 years from the date of the last entry in the record. For patients who are children, the regulation requires

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that the physician keep the record until 10 years after the day on which the patient reached or would have reached the age of 18 years. However, it is prudent to maintain records for a minimum of 15 years because, in accordance with the *Limitations Act*, some legal proceedings against physicians can be brought 15 years after the act or omission on which the claim is based took place.¹¹

Physicians may also be required to retain records longer than the above time periods when they receive a request for access to personal health information. Where such a request has been made, physicians must retain the personal health information for as long as necessary to allow for an individual to take any recourse that is available to them under *PHIPA*.

The retention rules are different for physicians who cease to practise medicine, please see below for more detail. See Appendix A for the applicable regulation.

Patient Requests Transfer

If a patient requests that a physician transfer his or her records, the transfer should take place in a timely fashion. The physician may charge the patient a reasonable fee to reflect the cost of the materials used, the time required to prepare the material and the direct cost of sending the material to the requesting physician.¹² Prepayment of the fee for a transfer of medical records may only be requested when, in the best judgment of the treating physician, the patient's health and safety will not be put at risk if the records are not transferred.

In some circumstances, it will be desirable for the transferring physician to prepare a summary of the records rather than to provide a copy of the whole record. This is acceptable to the College as long as it is acceptable to the receiving physician and the patient. The physician is still obligated to retain the original record, in its entirety, for the time period required by regulation.

The obligation to pay the account rests with the patient or with the third party who has requested the

records. Fulfilling such a request is an uninsured service and reasonable attempts may be made on the part of the physician to collect the fee.

Physician Relocates

Physicians relocating their practice have the option to take the medical records with them or leave the records with a designated custodian, as long as there is an agreement that the patient will be permitted access to them, as required.

Physician Ceases Practice

There are myriad ways in which practices end and the College recommends that the physician or those responsible for winding up his or her practice act in the patients' best interests by ensuring that patients have access to their records.

When physicians cease to practice medicine (either because they no longer maintain their certificate of registration¹³ or they've died) two options are available with respect to patient records. The medical records may be transferred to another physician at the same address and phone number or they may be retained (either personally or through the use of a commercial record storage company).

Before patient records are transferred to a physician's successor, the physician or his or her representative must make a reasonable effort to give notice to patients, or where this is not reasonably possible, the physician or his or her representative must notify patients as soon as possible after the transfer has occurred.¹⁴

If the medical records pertain to family medicine or primary care, where a physician is not transferring records to another physician at the same location, the physician or his or her representative must notify each patient that the records will only be held for two years, and should suggest that patients collect their records or request a transfer of their records to another physician before this two-year period expires.

¹¹ The *Limitations Act (Limitations Act, 2002, S.O. 2002, c. 24, Sched. B)* provides that there is no limitation period in respect of a proceeding arising from a sexual assault, if at the time of the assault, the victim was a patient of the accused physician.

¹² Physicians can obtain the Third Party Billing Protocol from the OMA for advice about what fees are recommended.

¹³ This would include physicians whose certificates of registration have been suspended or revoked.

¹⁴ *PHIPA*, subsection 42(2).



Notification of patients may take place by way of a notice in the newspaper, direct communication with each patient, or in some other way that ensures that patients will receive notice. In all other situations, the rule requiring record maintenance for a minimum of 10 years will apply.

While the obligation to retain records when the physician ceases practice continues for only two years, the College recommends that, where possible, every effort should be made to ensure all patient records are transferred or remain available to patients until they find another physician.

The College notes that in many cases the physician may find it most convenient to rely on the services of a commercial record storage provider.

Destroying Medical Records

When the obligation to store medical records comes to an end, the records should be destroyed in a way that is in keeping with the obligation of maintaining confidentiality. Each year, the College complaints department receives calls from individuals who have found medical records in garbage or recycling bins, or blowing down the street. The College recommends that physicians shred all paper medical records (confidential shredding services are available for large quantities of records) and reminds physicians that electronic records must be permanently deleted from all hard drives,¹⁵ as well as other storage mechanisms.

Physicians must not dispose of a record of personal health information unless his or her obligation to retain the record has come to an end. Physicians are reminded that obligations to retain records may arise under *PHIPA* (because a patient has requested access, for example) and disposal of the record under such circumstances would be an offence under section 72(1) of *PHIPA*.

Medical Records in a Group Practice or Employment Setting

Termination of a Group Practice Agreement

Physicians in a group practice setting must have an agreement that establishes responsibility for maintaining and transferring patient records upon dissolution.

Typically, the agreement will address such items as:

- The method for division of medical records upon termination of the practice arrangement. The agreement usually specifies a method of identifying custody of the medical records.
- Reasonable access to the content of the medical records for each physician to allow him or her to prepare medico-legal reports, defend legal actions, or respond to a complaints investigation.

If no such agreement exists, physicians dissolving a group practice must agree upon a system to determine who is the 'most responsible physician' for each record. For example, the physician who has created the greatest percentage of the entries in a particular patient record may be expected to continue to maintain it.¹⁶

Ask the Patient

Ultimately, if a group practice dissolves, the patient's best interests will likely be served by ascertaining which physician the patient wishes to continue seeing. If the patient is following a physician to a different practice location, the records should be transferred, and physicians should agree how the cost of copying and transferring records will be divided within the group. In the case of planned group practice dissolution, the cost cannot be charged to the patient.

Unexpected Dissolution of a Group Practice

An unexpected dissolution of a group practice creates special difficulties. Ideally, physicians involved should amicably agree upon a strategy for informing patients and dealing with the medical records. In the case of a sudden, unforeseen departure of a partner or associate,

¹⁵ It may not be possible to permanently delete records from a computer's hard drive. In most cases, it will be preferable to destroy the hard drive altogether.

¹⁶ Physicians involved in a Family Health Network or other primary care arrangement should consult their contracts to determine whether special rules apply. Generally speaking, the patient must be given notice that the departing physician is leaving the arrangement and provided with the opportunity to remain with the practice.

Medical Records

records should be kept at the original location until the patient directs where he or she wishes to receive ongoing health care. Reasonable access to medical records must be given to all former partners and associates.

When the Physician is an Employee

Physicians who are employees should satisfy themselves that there is an agreement with the employer about patient record retention and transfer.

7. CONFIDENTIALITY¹⁷

In most cases, it is professional misconduct to give information concerning the condition of a patient or any services rendered to a patient to any other person except with the consent of the patient.¹⁸ However, there are some instances in which physicians are able to, or are required to, disclose personal health information without patient consent. Examples of these situations are included below. For further detail, physicians should consult the College's Confidentiality of Personal Health Information policy.

Withdrawal of Consent and Conditional Consent

Physicians should be aware that patients are entitled to withdraw their consent to the disclosure of their personal health information. While this withdrawal will not affect disclosures made prior to the withdrawal, it will apply to any disclosures made after the withdrawal. Physicians should exercise care and caution when disclosing personal health information, once the patient has withdrawn his or her consent regarding disclosure.

There may be some situations in which patients will give their consent to the collection, use or disclosure of their personal health information, but will impose conditions or restrictions on the manner in which their information is used or disclosed. Where patients wish to give conditional consent, physicians should ask patients to set out any and all restrictions in writing. No restriction or condition imposed by a patient shall prevent physicians from recording information that is required by law, by standards of professional

practice, or by standards of institutional practice. The physician disclosing the record must indicate on the record that clinically relevant information is missing from it.

Inability to Consent Due to Incapacity

A determination of incapacity with respect to the consent to collection, use or disclosure of personal health information may be different from a determination of incapacity with respect to consenting to health care under the *Health Care Consent Act, 1996*.

With respect to substitute consent in the case of an incapable patient, physicians should consult section 23 of *PHIPA* to determine who may be capable of giving, withholding or withdrawing consent.

Patient Access to Records

Generally speaking, all information contained in the record must be released to patients upon request, including letters from consultants, even when such letters are stamped or indicated as confidential documents. However, in very limited circumstances, physicians can use their discretion and refuse to provide patients with access to their records. Physicians should consult section 52 of *PHIPA* for a comprehensive list of such circumstances. Examples include situations where the information was collected for use in a proceeding (e.g., a proceeding in a Court or before a committee of the College), or where granting access could reasonably be expected to result in a risk of serious bodily harm.

Physicians cannot refuse to grant a patient access to their records for the purpose of avoiding a legal proceeding.

If a physician has refused a patient access to his or her medical record, the patient has the right to challenge the physician's decision in Court under subsection 54(8) of *PHIPA*.

Providing Information to Third Parties

Providing information to third parties can be a complex matter. When in doubt, physicians should con-

¹⁷ See the CPSO policy on Confidentiality of Personal Health Information for further information.

¹⁸ Professional Misconduct "1(1) The following are acts of professional misconduct for the purposes of clause 51(1)(c) of the *Health Professions Procedural Code*:

10. Giving information concerning the condition of a patient or any services rendered to a patient to a person other than the patient or his or her authorized representative except with the consent of the patient or his or her authorized representative or as required by law." (O. Reg. 53/95).



sult their lawyer or the CMPA for advice.

A physician may not provide any information concerning the patient to a third party unless the patient or the patient's authorized representative consents to this disclosure, or the physician is required by law to disclose the information.

PHIPA sets out some circumstances in which physicians are permitted to disclose information without patient consent or the consent of an authorized representative. These include:

- Situations where the information is needed to provide health care to the patient, or to assist in the provision of health care to the patient;
- The information is needed to manage or allocate resources in the health care system.

Other legislation establishes situations in which physicians are required to report personal health information to a third party. These are set out at length in the College's Mandatory Reporting policy. Some examples include:

- When a physician has reason to think a patient may be unsafe to drive, he or she may have an obligation to report to a medical advisor designated by the Minister of Transportation.
- When a physician has reason to think that a child is in danger, he or she will have an obligation to report that concern to the local Children's Aid Society.
- When a patient discloses information that makes the physician suspect that another person's life is in danger, the physician will have an obligation to report that information to the police.
- When a patient is lawfully detained in a jail or detention centre and the information is required to assist in the decision to place the patient into custody, detention, release, conditional release, discharge, or conditional discharge, a physician may disclose information to the entity but should only do so when the entity indicates the decision that is being contemplated; the nature of the information

that is necessary for the decision; why the information is necessary; and how the information will be used or disclosed in relation to reaching the stated decision.

Summonses, Subpoenas and Court Orders

Physicians may be required by a summons, subpoena or a Court Order to disclose personal health information and patient records in the course of litigation. The litigation will usually involve the patient. The physician should read the summons, subpoena or Court Order carefully and do everything it requires but no more than it requires. For example, a summons may require a physician to attend a Court at a particular time and take a specific patient chart. That summons does not authorize the physician to discuss the patient's care, or show the record to anyone in advance of the Court appearance.

Deceased Patients

Ideally, a physician should disclose personal health information about a deceased patient only with the consent of the trustee for the patient's estate or the person who has assumed that responsibility if the estate does not have a trustee. Physicians are permitted to disclose information about a deceased patient for the purpose of identifying the individual; informing anyone it is reasonable to inform of the patient's death and, where appropriate, the circumstances of the patient's death; and to the patient's spouse, partner, sibling or child, if they reasonably require the information to make decisions about their own health care or about the health care of their children.¹⁹

Many circumstances involving deceased patients are too complex for simple advice. When confronted with a difficult decision, physicians should call the CMPA or their lawyer.

Minor Patients

There is a point at which a child becomes responsible for decisions about disclosure of his or her own records. There is no legal minimum age for consent to

¹⁹ PHIPA, subsection 38(4).

Medical Records

the disclosure of personal health information. However, when a minor patient becomes mature enough to make decisions about his or her own health care and disclosure of records, and understand the consequences of such decisions, then parents and other third parties can no longer access records without consent.²⁰

Minor Patients of Separated Parents

The *Children's Law Reform Act* permits an 'access parent' of a minor child to obtain personal health information about that child. However, many other factors may affect the right of an access parent to the personal health information of their child, such as a Court Order, a separation agreement, a marriage contract, or the fact that the parents live outside Ontario. Therefore, unless the physician understands the family situation and has the consent of both parents, the physician should seek advice from the CMPA or his or her lawyer before providing information to an access parent.

Refusal to Disclose

Physicians may refuse a request for access to information from a third party where:

- The information is protected by solicitor-client privilege;
- Granting access would have the effect of revealing confidential commercial information;
- It is reasonable to expect that granting access would threaten the life or security of another individual;
- The information was collected in relation to a breach of an agreement or a contravention of federal or provincial laws; or
- The information was generated in relation to a formal dispute resolution process.

APPENDIX A

Components of Medical Records Required By Law – Ontario Regulation 114/94, Sections 18, 19, 20 and 21, made under the *Medicine Act, 1991*.

Many of the components of the medical record are legally required as defined in Ontario Regulation

114/94, made under the *Medicine Act, 1991*:

18. (1) A member shall make records for each patient containing the following information:

1. The name, address, and date of birth of the patient.
2. If the patient has an Ontario health number, the health number.
3. For a consultation, the name and address of the primary care physician and of any health professional who referred the patient.
4. Every written report received respecting the patient from another member or health professional.
5. The date of each professional encounter with the patient.
6. A record of the assessment of the patient, including,
 - i. the history obtained by the member,
 - ii. the particulars of each medical examination by the member, and
 - iii. a note of any investigations ordered by the member and the results of the investigations.
7. A record of the disposition of the patient, including,
 - i. an indication of each treatment prescribed or administered by the member,
 - ii. a record of professional advice given by the member, and
 - iii. particulars of any referral made by the member.
8. A record of all fees charged which are not in respect of insured services under the *Health Insurance Act*, which may be kept separately from the clinical record.
9. Any additional records required by regulation.

(2) A member shall keep a day book, daily diary or appointment record containing the name of each patient who is encountered professionally or treated or for whom a professional service is rendered by the member.

²⁰ See the CPSO Consent to Medical Treatment policy.



- (3) The records required by regulation shall be,
- legibly written or typewritten or made and kept in accordance with section 20; and
 - kept in a systematic manner.
- 19.** (1) A member shall retain the records required by regulation for at least ten years after the date of the last entry in the record, or until ten years after the day on which the patient reached or would have reached the age of eighteen years, or until the member ceases to practise medicine, whichever occurs first, subject to subsection (2).
- (2) For records of family medicine and primary care, a member who ceases to practise medicine shall,
- transfer them to a member with the same address and telephone number, or
 - notify each patient that the records will be destroyed two years after the notification and that the patient may obtain the records or have the member transfer the records to another physician within the two years.
- (3) No person shall destroy records of family medicine or primary care except in accordance with subsection (1) or at least two years after compliance with clause (2)(b).
- 20.** The records required by regulation may be made and maintained in an electronic computer system only if it has the following characteristics:
- The system provides a visual display of the recorded information.
 - The system provides a means of access to the record of each patient by the patient's name and, if the patient has an Ontario health number, by the health number.
 - The system is capable of printing the recorded information promptly.
 - The system is capable of visually displaying and printing the recorded information for each patient in chronological order.
 - The system maintains an audit trail that,
 - records the date and time of each entry of information for each patient,

- indicates any changes in the recorded information,
 - preserves the original content of the recorded information when changed or updated, and
 - is capable of being printed separately from the recorded information for each patient.
- The system includes a password or otherwise provides reasonable protection against unauthorized access.
 - The system automatically backs up files and allows the recovery of backed-up files or otherwise provides reasonable protection against loss of, damage to, and inaccessibility of, information.

21. A member shall make his or her equipment, books, accounts, reports and records relating to his or her medical practice available at reasonable hours for inspection by a person appointed for the purpose under a statute or regulation.

APPENDIX B

Self-Evaluation: Assess Your Own Medical Records

Auditing your own medical records can help you identify the strengths and weaknesses of your current system.

Every year the College reviews hundreds of physicians' medical records. Through the College's peer assessment activities alone, the records of 500 physicians are reviewed.

The list on the following page comes directly from the protocol used in the CPSO's peer assessment activities. Use this list to review your own record keeping practice, and to identify areas of strength and weakness in your documentation.

Always	Needs Improvement	N/A	Medical Record Keeping Activity
			My record keeping system allows for ready retrieval of an individual patient file.
			My records are legible.
			The patient's identity is clearly evident on each component of the file.
			Each patient file clearly shows full name, address, date of birth, and gender.
			The date of each visit or consultation is recorded.
			The family history, functional inquiry, and past history (including significant negative observations) is recorded and maintained.
			Allergies are clearly documented.
			Dates of immunization (if relevant) are clearly visible.
			A "cumulative patient profile" (summary sheet) relating to each patient is present and fully maintained.
			The chief complaint is clearly stated.
			The duration of symptoms is noted.
			An adequate description of the symptoms is present.
			Positive physical findings are recorded.
			Significant negative physical findings are recorded.
			Requests for laboratory tests, x-rays, and other investigations are documented.
			Requests for consultations are documented.
			The diagnosis or provisional diagnosis is recorded.
			The treatment plan and/or treatment is recorded.
			Doses and duration of prescribed medications are noted.
			Progress notes relating to the management in the office of patients suffering from chronic conditions are made.
			Pathology reports are retained.
			Hospital discharge summaries are retained.
			Operative notes are retained.
			There is documented evidence that periodic general assessments are being performed.
			There is documented evidence that health maintenance is periodically discussed (topics such as smoking, alcohol consumption, obesity, life style, etc.)
			There is evidence that the physician periodically reviews the list of medications being taken by patients suffering from multiple or chronic conditions.
			There is a system in place to clearly show that abnormal test results come to the attention of the physician. For example, the reports are initialed.
			There is documented evidence that appropriate follow-up has taken place following receipt of such abnormal test results.
			In the event that more than one physician is making entries in the patient file, is each physician identifiable?
			Paediatric growth charts are used.
			Ontario Antenatal forms are used.



APPENDIX C

Section 37.1 - Ontario Health Insurance Act, R.S.O. 1990, c.H.6

The Ontario *Health Insurance Act* stipulates the following:

37.1.- (1) For the purposes of this *Act*, every physician, practitioner and health facility shall maintain such records as may be necessary to establish whether he, she or it has provided an insured service to a person.

(2) For the purposes of this *Act*, every physician, practitioner and health facility shall maintain such records as may be necessary to demonstrate that a service for which he, she or it prepares or submits an account is the service that he, she or it provided.

(3) For the purposes of this *Act*, every physician and health facility shall maintain such records as may be necessary to establish whether a service he, she or it has provided is medically necessary.

(4) For the purposes of this *Act*, every practitioner and health facility shall maintain such records as may be necessary to establish whether a service he, she or it has provided is therapeutically necessary.

(5) The records described in subsections (1), (2), (3) and (4) must be prepared promptly when the service is provided.

(6) If there is a question about whether an insured service was provided, the physician, practitioner or health facility shall provide the following persons with all relevant information within his, her or its control:

1. The General Manager.
2. An inspector who requests the information.
3. In the case of a physician or health facility, a member of the Medical Review Committee who requests the information.
4. In the case of a practitioner or health facility, a member of the applicable practitioner review committee who requests the information.

(7) In the absence of a record described in subsection (1), (2), (3) or (4), it is presumed that an insured service was provided and that the basic fee payable is nil.

If you have any questions regarding the OHIP Schedule of Benefits, you should contact your local branch of OHIP or the Provider Services Branch of the Ministry of Health and Long-Term Care.

APPENDIX D

The following organizations may be able to provide additional information:

Canadian Medical Protective Association

875 Carling Avenue, 9th Floor
Ottawa, ON K1S 5P1
Tel: (613) 725-2000 Fax: (613) 725-1300
Toll-Free: (800) 267-6522
www.cmpa.org

College of Family Physicians of Canada

2630 Skymark Avenue
Mississauga, ON L4W 5A4
Tel: (905) 629-0900 Fax: (905) 629-0893
Toll-Free: (800) 387-6197
www.cfpc.ca

Ministry of Health and Long-Term Care

Provider Services Branch
49 Place d'Armes, 2nd Floor
Kingston, ON K7L 5J3
Tel: (613) 548-7878 (ask for the Provider Services Branch)
Fax: (613) 548-6309
www.health.gov.on.ca

Ontario Medical Association

525 University Avenue, Suite 300
Toronto, ON M5G 2K7
Tel: (416) 599-2580 Fax: (416) 340-2996
Toll-Free: (800) 268-7215
www.oma.org

Royal College of Physicians and Surgeons of Canada

774 Echo Drive
Ottawa, ON K1S 5N8
Tel: (613) 730-8177 Fax: (613) 730-8830
Toll-Free: (800) 668-3740
www.rcpsc.medical.org

APPENDIX F

Flow Sheet — sample condition specific forms — Diabetes Mellitus

Generic Diabetes Flow Sheet									
DIABETES FLOW SHEET					<input type="radio"/> Type I			<input type="radio"/> Type II	
Patient Name:									
Age at diagnosis:					Date of diagnosis:				
Semi-Annual Screen									
Date									
Blood Pressure									
Weight									
BMI 27									
HbA _{1c} 140									
Urine R&M									
Last eye exam									
Serum lipids									
Check feet									
μ-albuminuria (annual)									
Hypoglycemic Therapy									
Date									
Home monitor									
AM therapy									
PM therapy									
Long-Term Complications (Insert Dates)									
DKA									
Hyperosmolar state									
Retinopathy									
Nephropathy									
CAD									
CVA/TIA									

DIABETIC CARE FLOW SHEET

Name:	Date of Diagnosis - Type 1:	Type II:
Self Blood Monitoring? Yes / No	EKG:	Ace Inhibitor: Yes / No
Endocrinologist:	Risk Factors:	

Time (months)	0	3	6	9	12	15	18	21	24
Date (mm/yy)									
CVS									
BP (each visit) (<130/80)									
BMI/Weight (each visit)									
Oculovisual									
Peripheral Neuropathy									
Foot exam (each visit)									
FP Glucose (4-6 months)									
Hb A1C (2-4 months)									
Fasting Chol., HDL, LDL, Trig (q 1-3 years)									
Serum Creat, and K (biannual)									
TSH (Type 1)									
Urine Dipstick									
AC (alb. creat) ratio (R) annual									
24 hour urine microalbuminuria (yearly)									
Lifestyle/Education (diet, ETOH, exercise, smoking)									
Optometrist/Opth. (1-4 yrs)									
Dietitian									
Chiroprapist									
Pneumovax/Influenza Vac.									
Medications: Review Each Visit									

Reference: Canadian Clinical Practice Guidelines for Management of Diabetes Mellitus, 1998.

Courtesy: Victoria Family Medical Centre

MEDICAL RECORDS



COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO

80 COLLEGE STREET, TORONTO, ONTARIO M5G 2E2