# State of Florida

# *GENERAL RECORDS SCHEDULE GS4*
# *FOR*
# *PUBLIC HOSPITALS, HEALTH CARE FACILITIES AND MEDICAL PROVIDERS*


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R. 1B-24.003(1)(d), *Florida Administrative Code*

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# FLORIDA DEPARTMENT OF STATE
# GENERAL RECORDS SCHEDULE GS4
# PUBLIC HOSPITALS, HEALTH CARE FACILITIES AND MEDICAL PROVIDERS

**ACCREDITATION RECORDS: SURVEY AND INSPECTION REPORT (Item # 1)**

This record series consists of accreditation survey results, inspection reports by accrediting institutions, notices of corrections, correction reports, and in-house surveys and testing done prior to the actual accreditation survey. Also included in this series are public notices required by accrediting organizations, public hearing transcripts, and any additional supporting materials necessary for the survey, inspection, and correction of deficiencies. This applies to all certifying agencies, whether state, federal, or professional organizations. This series may be used by a specific department or for the hospital as a whole. ***This series may have archival value.***

**RETENTION:**

a) Record copy. 5 years after next accreditation report is issued.
b) Duplicates. Retain until obsolete, superseded or administrative value is lost.

**ADMISSION REPORTS: STATISTICAL (Item # 2)**

This record series consists of statistical admission reports. These reports do not give personal identifying information such as name and address. These reports contain statistical data used to abstract various factors. Data may include the number of patients in a particular ward such as maternity or intensive care, the number of patients admitted for each hour of the day, the number of trauma patients in a day, etc.

**RETENTION:**

a) Record copy. 3 fiscal years.
b) Duplicates. Retain until obsolete, superseded or administrative value is lost.

**AIR SAMPLING AND BIOASSAYS (Item # 107)**

This record series consists of the results of air sampling and bioassays as well as surveys conducted in the radiology section which are sufficient enough to identify potential hazards, permit proper equipment selection, estimate exposure levels, and to evaluate actual intake levels. The air sampling, surveys, and bioassays are part of the required Respiratory Protection Program. 10D-91.471 & 10D-91.452, FAC

**RETENTION:**

a) Record copy. 1 year after expiration or termination of license.
b) Duplicates. Retain until obsolete, superseded or administrative value is lost.

**AUDITS: RADIATION PROTECTION PROGRAM (Item # 108)**

This record series consists of any audits or reviews conducted by the state or federal government, a consultant, or radiology provider on the Radiation Protection Program. The audit or review evaluates the program's content and implementation. Proof of corrective actions may also be included in this series. 10D-91.470, FAC

**RETENTION:**

a) Record copy. 3 years.
b) Duplicates. Retain until obsolete, superseded or administrative value is lost.

**BIOMEDICAL WASTE RECORDS (Item # 96)**

This record series consists of: training records, which document that staff members were instructed on the proper handling and disposition of biomedical wastes; copies of signed biomedical tracking forms generated by the disposing agency and signed by the owner/operator of the destination facility as required by 40 CFR 259.52; exception forms required by biomedical waste producers under 40 CFR 259.55c; original mail receipts generated when an agency transports regulated medical waste by the U.S. Postal Service as well as the return receipt; and the shipment log maintained by the original generating point and any central receiving facilities. Shipment logs contain the date of shipment, the quantity by weight and the category of waste shipped, the address and location of the central collection point and the original generating point, signatures as required, and the date of receipt by a central receiving point. This log may also contain the name and address of the transporter and the transporter's state permit or license number. The exception form is completed by a generator if they do not receive a completed signed copy of the tracking form from the owner/operator of the destination facility within 45 days after shipment. The exception form is submitted to the EPA Regional Administrator and the appropriate state agency. This form includes a legible copy of

**BIOMEDICAL WASTE RECORDS (Item # 96) CONTINUED**

the tracking form for which there is no confirmation of delivery and a signed cover letter explaining the generator's efforts in locating the waste and the results of those efforts. 10D-104.003, FAC and 40 CFR 259.54, .55, .60

**RETENTION:**

a) Record copy. 3 calendar years.

b) Duplicates. Retain until obsolete, superseded or administrative value is lost.

**BIRTH RECORDS/CERTIFICATES (Item # 6)**

This record series consists of vital birth records and certificates filed with state registrar of vital statistics. This series may include any birth record, or amendments thereto, in certificate form or in report form as collected by the county health officer, as well as the penny post cards issued in the 1900s and the birth ledgers of cities created before the Bureau of Vital Statistics. ***This series may have archival value.***

**RETENTION:**

a) Record copy. Permanent.

b) Duplicates. Retain until obsolete, superseded or administrative value is lost.

**BIRTH REPORTS (Item # 102)**

This record series consists of reports submitted by the medical facility to the County Public Health Unit every five days on diskette. The report contains all necessary information for the completion of the birth certificate including baby's name, weight, height, time/date/location of birth and information on the baby's parents. The record copy is retained by the Office of Vital Statistics for the generation of a birth certificate. Copies of this report maintained by the hospital are duplicates.

**RETENTION:**

a) Record copy. 1 year after birth certificate is issued.

b) Duplicate. Retain until obsolete, superseded or administrative value is lost.

**BLOOD BANK RECORDS (Item # 122)**

This record series consists of documents maintained in a blood bank which record the donor information, storage and distribution of the product, compatibility testing, quality control records, transfusion reaction reports and complaints, and general records. This series also includes the logs which indicate on-hand inventory and notices of emergency shortages. General records are described as records of the sterilization of supplies and reagents, responsible personnel, errors and accidents, maintenance of equipment and the physical plant, and the expiration dates of supplies and reagents. Quality control records include: calibration and standardization of equipment, performance checks, periodic check of sterile technique, and periodic tests of the capacity of shipping containers to maintain the proper temperature. Compatibility tests include the results of cross-matching, antibody screenings, and the results of confirmation testing. Storage and distribution records include: the distribution and disposition of the blood product; visual inspection of whole blood and red blood cells during storage and immediately before distribution; storage temperature control and initialed temperature log or recorder chart; and emergency releases of blood including a physician's signature. Donor records include: donor selection , informed consent, medical interview and examination, permanent and temporary deferrals, donor adverse reaction complaints and reports, investigation and follow-up, therapeutic bleedings, immunization, and blood collection including phlebotomist's name. This series relates to JCAHCO standard QC5.1.7. THE RETENTION IS 6 MONTHS AFTER THE PRODUCT'S EXPIRATION DATE; HOWEVER, **IF THERE IS NO EXPIRATION DATE, THE RECORDS ARE RETAINED PERMANENTLY**. 21 CFR 606.160, .165, .170, and .151

**RETENTION:**

a) Record copy. 186 days after expiration.

b) Duplicates. Retain until obsolete, superseded or administrative value is lost.

**CANCER REGISTRY REPORTS** **(Item # 10)**

This record series consists of cancer registry reports which were required by HRS in 1972 and discontinued in 1977. These reports are no longer created but may still be in storage. The report identified the type of cancer, its growth and location, the treatments prescribed and their effectiveness, and the age, gender, and race of the patient.
RETENTION:
a) Record copy. 75 calendar years after last entry; microfilm optional.
b) Duplicates. Retain until obsolete, superseded or administrative value is lost.

**COMPLAINT RECORDS: MAMMOGRAPHY FACILITY** **(Item # 91)**

This record series consists of the complaint filed by an employee or patient against a mammography provider and the results of the accrediting body's investigations. 21 CFR 900.4 and 95.11 F.S.
**RETENTION:**
a) Record copy. 7 years after investigation.
b) Duplicates. Retain until obsolete, superseded or administrative value is lost.

**COST CONTAINMENT REPORTS** **(Item # 20)**

This record series consists of Cost Containment and Prior Year Actual Reports submitted by a medical provider to AHCA, formerly called the Hospital Cost Containment Board, in compliance with the Florida Hospital Uniform Reporting System. These reports are required under FAC Rule 59E-5.103.
**RETENTION:**
a) Record copy. 5 calendar years
b) Duplicates. Retain until obsolete, superseded or administrative value is lost.

**DEATH CERTIFICATES** **(Item # 22)**

This record series consists of death certificates. The record (master) copy should be filed with state registrar of vital statistics or county health officer. The duplicate should be filed in the patient's medical file. ***This series may have archival value.***
**RETENTION:**
a) Record copy. Permanent; microfilm optional.
b) Duplicates. Retain as long as the item it relates to.

**DELIVERY ROOM LOGS** **(Item # 23)**

This record series consists of a log detailing in chronological order the names of who utilized the delivery room and when. The log then cross references this information with a patient identification number for tracking or billing purposes. These logs are primarily paper-based, although a more sophisticated form could exist in a computerized environment.
**RETENTION:**
a) Record copy. 10 years.
b) Duplicates. Retain until obsolete, superseded or administrative value is lost

**DIETARY RECIPE RECORDS: STANDARDIZED** **(Item # 28)**

This record series consists of standardized dietary recipe records used in the preparation of patient meals by the kitchen staff. Recipes records may include a nutritional analysis, ingredients list, and serving size notation.
**RETENTION:**
a) Record copy. Retain until obsolete, superseded or administrative value is lost
b) Duplicates. Retain until obsolete, superseded or administrative value is lost

**DIETITIAN COUNSULTING: INSTITUTIONS (Item # 111)**
This record series consists of annual summaries provided by a nutritionist or dietitian to health care facilities and group homes which do not have a professional on staff. These summaries evaluate the menus, sanitation, policies and procedures, and recommend modifications for the food preparation and service department. 10F-6.010, FAC
**RETENTION:**
a) Record copy. 2 years.
b) Duplicates. Retain until obsolete, superseded or administrative value is lost.

**EKG/EEG/FETAL HEART MONITOR STRIPS (Item # 118)**
This record series consists of the actual strips generated by various vital sign monitors and testing devices where a report or interpretation has been recorded in the patient medical record. This series does NOT apply to strips generated where no report of their content is contained within the patient's medical file. In those cases the strips would take the retention of the patient medical record.
**RETENTION:**
a) Record copy. 30 days after report is filed.
b) Duplicates. Retain until obsolete, superseded or administrative value is lost.

**FINAL TEST REPORTS: PATHOLOGY (Item # 85)**
This record series consists of the legally reproduced copies of each test result and preliminary reports on pathology testing. This series is specific to pathology, histology, and cytology records. Documentation includes all the information recorded on the test requisition plus the specimen's accession number, the date and time the lab received the specimen, the condition and disposition of samples which do not meet the lab's acceptance standards, the records and dates of performance of each step in the patient testing leading to and including the final report. 42 CFR 493.1101
**RETENTION:**
a) Record copy. 10 years.
b) Duplicates. Retain until obsolete, superseded or administrative value is lost.

**GUNSHOT WOUND REPORTS: HOSPITAL COPY (Item # 128)**
This record series consists of a report made by any physician, nurse, or employee thereof, who knowingly treats any person suffering from a gunshot wound or other wound indicating violence or receives a request for such treatment. This report is made to the sheriff of the county where the request for treatment is placed or care is rendered. The record copy is retained by the medical provider. The sheriff's copy is scheduled in the GS2 for Law Enforcement Agencies.
**RETENTION:**
a) Record copy. 30 Days.
b) Duplicate. Retain until obsolete, superseded or administrative value is lost.

**INCIDENT RECORDS (Item # 40)**
This record series consists of a report of an unusual incident which is recorded by a witness to the incident in a formal manner such as a log, event book, incident form, etc. The incident report includes: the time, date, and location of the event; the nature of the incident; the persons involved and names of witnesses; a description of the events which took place; the time police, security, EMS, or the fire department was called and by whom; the supervisor on duty; the types of equipment used and by whom; and remarks on whether follow-up by the next shift is necessary. This series may be used to report security or injury incidents or to note disturbances in the work place such as fire alarms, roof leak, computer and power outages, car alarms, and other events. SEE ALSO "RISK MANAGEMENT REPORTS: INTERNAL"
**RETENTION:**
a) Record copy. 7 calendar years after incident.
b) Duplicates. Retain until obsolete, superseded or administrative value is lost

**INFECTION CONTROL PROGRAM: REPORTS (Item # 131)**
This record series consists of surgical infection investigation reports, training course content and the review and evaluation of all septic, isolation, and sanitation techniques used in the medical facility. Also included in this series are reports on an employee who may have or has been exposed to a communicable disease, their work restrictions, and estimated date of reinstatement. These reports are part of the agency's attempt to identify, report, evaluate, and maintain records of infections. 59A-3.215, FAC SEE ALSO "RISK MANAGEMENT REPORTS: INTERNAL"
**RETENTION:**
a) Record copy. 5 calendar years.
b) Duplicates. Retain until obsolete, superseded or administrative value is lost.

**INSPECTIONS: RADIOLOGY SECTION (Item # 101)**
This record series consists of the results of a federal, state, or consulting physicist's inspection of the radiological services section, as well as the records of any actions taken to correct the identified deficiencies. 59A-3.228, FAC
**RETENTION:**
a) Record Copy. 2 years after compliance.
b) Duplicates. Retain until obsolete, superseded or administrative value is lost.

**INVENTORY RECORDS: DRUG (Item # 127)**
This record series consists of all required inventories pertaining to drugs held by health care providers, including pharmacists and EMS units. This series contains records for controlled substances classifications I, II, III, IV, and V, and applies to practitioners, institutions, and pharmacies. In the case of an EMS unit, inventories of each controlled substance placed on or removed from the vehicle are conducted at the beginning and ending of each shift. A written log with consecutive and permanently numbered pages accompanies the inventory. The log shall specify: the vehicle number; the name of the employee conducting the inventory; the date and time of the inventory; the name, weight, volume or quantity, and expiration date of each substance; the run report number if applicable; each amount administered; the printed name and signature of the administering paramedic or other authorized licensed official; and the printed name and signature of persons witnessing the disposal of unused portions. Pharmacies should maintain an inventory of all controlled substances received which shows the date receipt, the name and address of the sender, and the kind and quantity of controlled substances received. Pharmacies must record all controlled substances sold, administered, dispensed, or otherwise disposed of, including the date of sale, administration, or dispensing. This record should also include the correct name and address of the person to whom dispensed, or the owner and species of animal for which sold, administered, or dispensed. Documentation and inventorying of all out-dated drugs, their segregation from all other drugs, and either their return to the manufacturer or distributor or their destruction are also part of this record series. ' 499.0121 and 893.07, FS, and 21 CFR 1304.04
**RETENTION:**
a) Record copy. 2 years.
b) Duplicates. Retain until obsolete, superseded or administrative value is lost.

**INVENTORY: SEALED RADIATION SOURCES (Item # 115)**
This record series consists of the results of quarterly physical inventories which account for all sealed sources received or possessed under an appropriate license. This series details the quantities and kinds of radioactive material, the location of sealed sources, the date of the inventory, and the name of the staff member conducting the inventory. 10D-91.508, FAC
**RETENTION:**
a) Record copy. 2 years.
b) Duplicates. Retain until obsolete, superseded or administrative value is lost.

**MAINTENANCE/INSPECTION: RADIOGRAPHIC DEVICES (Item # 116)**
This record series consists of quarterly inspections and maintenance of radiographic exposure devices, storage containers, and source changers to assure proper functioning of these components. Maintenance is in accordance with the manufacturer's specifications. This series may also show that equipment was removed from service because damage during inspection was noted. This series does not include major repairs, parts replacement, or annual testing. 10D-91.510, FAC
**RETENTION:**
a) Record copy. 2 years.
b) Duplicates. Retain until obsolete, superseded or administrative value is lost.

**MAMMOGRAM FILM: SINGLE VISIT (Item # 90)**
This record series consists of the x-ray film taken to identify breast cancer in women, provided that this is the ONLY mammogram of the patient taken at this facility. This retention is for the actual film not the radiologist's interpretation of film. The interpretation is part of the Patient Medical Record. Retention for the films of patients who have had MORE than one mammogram at the facility are located under Item #78
"X-ray Films." This retention period was set by the federal Mammography Quality Standards Act.
**RETENTION:**
a) Record copy. 10 years.
b) Duplicates. Retain until obsolete, superseded or administrative value is lost.

**MANUALS, DIRECTIVES, PROCEDURES, POLICIES: SUPERSEDED (Item # 120)**
This record series consists of superseded, out-of-date manuals, policies, directives, procedures, and publications which have created or impacted medical procedure, policy, or operations in a health care facility. These records demonstrate the operational atmosphere and give guidance to medical staff on the care and treatment of a patient. These records are vital to malpractice cases as they
establish the conditions under which care was provided. Examples include nursing plans, dietary manuals, and risk management plans. 95.11, FS ***This series may have archival value.***
**RETENTION:**
a) Record copy. 7 years after superseded.
b) Duplicates. Retain until obsolete, superseded or administrative value is lost.

**MASTER PATIENT INDEXES (Item # 49)**
This record series consists of the patient's name, patient number, date of birth, date of admission, and the date of discharge, where applicable. Some institutions may include the patient's address and the diagnosis as part of this record. This record series may be entered on index cards or a computerized system. ***This series may have archival value.***
**RETENTION:**
a) Record copy. 10 years.
b) Duplicates. Retain until obsolete, superseded or administrative value is lost.

**MEASUREMENTS/CALCULATIONS: ENVIRONMENTAL EXPOSURE (Item # 123)**
This record series consists of the results of measurements and calculations used to evaluate the release of radioactive effluents into the environment. These results may be used to correct environmental damage to a specific location. 10D-91.471 FAC.
**RETENTION:**
a) Record copy. 1 year after expiration or termination of facility license.
b) Duplicates. Retain until obsolete, superseded or administrative value is lost.

**MEDICARE/MEDICAID RECORDS** **(Item # 132)**
This records series consists of all financial, administrative and program records associated with Medicare and Medicaid claims, reimbursement, and client activities. 409.907 and .913 F.S.
RETENTION:
a) Record copy. 5 fiscal years provided all audit issues have been resolved.
b) Duplicates. Retain until obsolete, superseded or administrative value is lost.

**MEDICARE/MEDICAID RECORDS: COUNTY HEALTH DEPARTMENTS** **(Item # 134)**
This records series consists of all financial, administrative and program records associated with Medicare and Medicaid claims, reimbursement, and client activities for County Health Departments under the Department of Health. FAC Rule 59G-4-.055(7).
RETENTION:
a) Record copy. 6 fiscal years provided all audit issues have been resolved.
b) Duplicates. Retain until obsolete, superseded or administrative value is lost.

**MENUS** **(Item # 54)**
This record series consists of the menus of actual food served by a intermediate care facility for the mentally handicapped, elder care facility, hospital, or other healthcare provider with food service capabilities. The menus list the variety of food choices available for a given meal or snack on a given day at a certain time. The dietitian's name, the date, and the average portion size may also be indicated. The meal and snack schedule should note the time and length of food service. 42 CFR 483.480 and 58A-5.020, FAC
**RETENTION:**
a) Record copy. 6 months.
b) Duplicates. Retain until obsolete, superseded or administrative value is lost.

**MINUTES: AIR AMBULANCE SAFETY COMMITTEE** **(Item # 125)**
This record series consists of the minutes taken during an air ambulance provider's safety committee meetings. Air medical providers are required by 10D-66.051(19), FAC, to hold quarterly safety committee meetings for the review of safety policies and procedures, unusual occurrences, safety issues, and audit compliance. ***This series may have archival value.*** See also GS1, "MINUTES: OFFICIAL MEETINGS (TRANSCRIPTS)," "MINUTES: OFFICIAL MEETINGS (AUDIO/VIDEO)," "MINUTES: OFFICIAL MEETINGS (SUPPORTING DOCUMENTS)," and "MINUTES: OTHER MEETINGS."
**RETENTION:**
a) Record copy. 2 years.
b) Duplicates. Retain until obsolete, superseded or administrative value is lost.

**MONITORING RECORDS: PACKAGES OF RADIOACTIVE MATERIALS** **(Item # 104)**
This record series consists of the results of calibrations required when a package containing radioactive materials is received by the radiology section. The section is required to monitor the package for radioactive contamination and excessive levels. The monitoring record would record the date and time a package was received, the time and date of calibration, the results and levels of the test, the name of the person who performed the test, as well as the time and date of notification of the carrier and the Department of Health if contamination or excessive levels exist. 10D-91.460 and 10D-91.471, FAC
**RETENTION:**
a) Record copy. 3 years.
b) Duplicates. Retain until obsolete, superseded or administrative value is lost.

**ON-SITE INCINERATOR RECORDS** **(Item # 97)**
This record series consists of acceptance records, the on-site incinerator form, and the operating log for an on-site incinerator. Acceptance records include documents which record the arrival of regulated medical waste to the on-site incinerator for disposal. Recorded in these documents are the date of acceptance, the state permit or license number of the transporter, the total weight of waste accepted, and the signature of

**ON-SITE INCINERATOR RECORDS** **(Item # 97)** **CONTINUED**

the receiver. The operating log includes the date of each incineration cycle, the length of the cycle, the total weight of waste incinerated per cycle, and an estimate of the weight of regulated medical waste incinerated per cycle. The on-site incinerator form is maintained by the operator and summarizes the information collected in the operating log. It includes the facility name, address, and location; facility type; contact person; waste feed information; and the total number of incinerators at the facility. This report must be certified as required. 40 CFR 259.61 and .62.

**RETENTION:**

a) Record copy. 3 calendar years.

b) Duplicates. Retain until obsolete, superseded or administrative value is lost.

**OPERATION INDEXES** **(Item # 60)**

This record series consists of indexes of surgical operations performed at the facility. These indexes may include in-patient as well as out-patient procedures, the name of surgeon or physician, the patient's name, and the time and date of the surgery. These indexes cross reference the use of the OR against a unique patient identification number for tracking and billing purposes. ***This series may have archival value.***

**RETENTION**:

a) Record copy. 10 years.

b) Duplicates. Retain until obsolete, superseded or administrative value is lost.

**PATIENT MEDICAL RECORD** **(Item # 80)**

This record series consists of the current and complete medical record for every patient seeking care or service from a healthcare provider or institution, including public providers of dental care and mental health and drug addiction counseling, multiphase clinics, hospitals, county public health units, medical/ dental/nursing schools, EMS providers, and limited care residential facilities. The medical record shall contain information required for the completion of a birth, death, or stillbirth certificate and may contain the following information: identification data; chief complaint or reason for seeking care; present illness; personal and family medical history; physical examination report; provisional and pre-operative diagnosis; clinical laboratory reports; radiology, diagnostic imaging, and ancillary testing reports; consultation reports; requisitions for laboratory tests; medical and surgical treatment notes and reports; evidence of appropriate informed consent; evidence of medication and dosage administered; a copy of the Florida Emergency Medical Services Report if delivered by ambulance; tissue reports; physician, nurse, and therapist progress notes and reports; principal and secondary diagnoses and procedures when applicable; discharge summary; appropriate social services reports; autopsy findings; individualized treatment plans; clinical assessments of patient's needs; certification of transfer of patient between facilities; routine inquiry form regarding organ donation in the event of death; operative reports and progress notes; postoperative information; referral sources; intake interviews; orientation program documentation; mental status examination and assessments; documentation of seclusion and restraints usage; if applicable a copy the form "Public Baker Act Service Eligibility;" physical, inhalation, speech, and occupational therapy plans, progress notes, and consultations; when applicable, Department of Health or Children and Families' forms for the reporting of child, elder, or domestic violence and trauma reports; anesthesia records; blood donor and transfusion information; organ receipt or tissue transplant records; data on a medical device transplant; bone marrow test reports; dialysis records; diet counseling and restriction notations; interpretations of the EEG, EKG, and fetal heart monitor tracings or if no tracings are reported - the actual tracings are included; infant screening test reports; nuclear medicine reports; x-ray interpretation records; growth charts and allergy history; emergency care rendered prior to arrival at the facility; time police or medical examiner notified; infection notices and follow-up; security notices for violent or unstable patients and accompanying family members; and adverse incident reports. Additional items may be included in the patient medical file on a case by case basis and under the recommendation of a professional or medical standards organization. 59A-3.214, FAC ***This series may have archival value.***

**RETENTION:**

a) Record copy. 7 years after last entry.

b) Duplicates. Retain until obsolete, superseded or administrative value is lost.

**PATIENT MEDICAL RECORD: CHILDREN UNDER ONE YEAR OF AGE (Item # 130)**

This record series consists of the current and complete medical record for every patient seeking care or service from a healthcare provider or institution, including public providers of dental care and mental health and drug addiction counseling, multiphase clinics, hospitals, county public health units, medical/dental/nursing schools, EMS providers, and limited care residential facilities. The medical record shall contain information required for the completion of a birth, death, or stillbirth certificate and may contain the following information: identification data; chief complaint or reason for seeking care; present illness; personal and family medical history; physical examination report; provisional and pre-operative diagnosis; clinical laboratory reports; radiology, diagnostic imaging, and ancillary testing reports; consultation reports; requisitions for laboratory tests; medical and surgical treatment notes and reports; evidence of appropriate informed consent; evidence of medication and dosage administered; a copy of the Florida Emergency Medical Services Report if delivered by ambulance; tissue reports; physician, nurse, and therapist progress notes and reports; principal and secondary diagnoses and procedures when applicable; discharge summary; appropriate social services reports; autopsy findings; individualized treatment plans; clinical assessments of patient's needs; certification of transfer of patient between facilities; routine inquiry form regarding organ donation in the event of death; operative reports and progress notes; postoperative information; referral sources; intake interviews; orientation program documentation; mental status examination and assessments; documentation of seclusion and restraints usage; if applicable a copy the form "Public Baker Act Service Eligibility;" physical, inhalation, speech, and occupational therapy plans, progress notes, and consultations; when applicable, Department of Health or Children and Families' forms for the reporting of child, elder, or domestic violence and trauma reports; anesthesia records; blood donor and transfusion information; organ receipt or tissue transplant records; data on a medical device transplant; bone marrow test reports; dialysis records; diet counseling and restriction notations; interpretations of the EEG, EKG, and fetal heart monitor tracings or if no tracings are reported - the actual tracings are included; infant screening test reports; nuclear medicine reports; x-ray interpretation records; growth charts and allergy history; emergency care rendered prior to arrival at the facility; time police or medical examiner notified; infection notices and follow-up; security notices for violent or unstable patients and accompanying family members; and adverse incident reports. Additional items may be included in the patient medical file on a case by case basis and under the recommendation of a professional or medical standards organization. s. 95.11(4)B, FS. ***This series may have archival value.***

**RETENTION:**

a) Record copy. Retain until Eighth Birthday.
b) Duplicates. Retain until obsolete, superseded or administrative value is lost.

**PATIENT MEDICAL RECORD: NURSING HOME MINORS (Item # 133)**

This record series consists of the complete medical record for every patient seeking care or service from a nursing home provider. The medical record shall contain information required for the completion of a birth, death, or stillbirth certificate and may contain the following information: identification data; chief complaint or reason for seeking care; present illness; personal and family medical history; physical examination report; provisional and pre-operative diagnosis; clinical laboratory reports; radiology, diagnostic imaging, and ancillary testing reports; consultation reports; requisitions for laboratory tests; medical and surgical treatment notes and reports; evidence of appropriate informed consent; evidence of medication and dosage administered; a copy of the Florida Emergency Medical Services Report if delivered by ambulance; tissue reports; physician, nurse, and therapist progress notes and reports; principal and secondary diagnoses and procedures when applicable; discharge summary; appropriate social services reports; autopsy findings; individualized treatment plans; clinical assessments of patient's needs; certification of transfer of patient between facilities; routine inquiry form regarding organ donation in the event of death; operative reports and progress notes; postoperative information; referral sources; intake interviews; orientation program documentation; mental status examination and assessments; documentation of seclusion and restraints usage; if applicable a copy the form "Public Baker Act Service Eligibility;" physical, inhalation, speech, and occupational therapy plans, progress notes, and consultations; when applicable, Department of Health or Children and Families' forms for the reporting of child, elder, or domestic violence and trauma reports; anesthesia records; blood donor and transfusion information; organ receipt or tissue transplant records; data on a medical device transplant; bone marrow test reports; dialysis records; diet counseling and restriction notations; interpretations of the EEG, EKG, and fetal heart monitor tracings or if

**PATIENT MEDICAL RECORD: NURSING HOME MINORS (Item # 133) CONTINUED**

no tracings are reported - the actual tracings are included; infant screening test reports; nuclear medicine reports; x-ray interpretation records; growth charts and allergy history; emergency care rendered
prior to arrival at the facility; time police or medical examiner notified; infection notices and follow-up; security notices for violent or unstable patients and accompanying family members; and adverse incident reports. Additional items may be included in the patient medical file on a case by case basis and under the recommendation of a professional or medical standards organization. 59A-4.118, FAC and s. 95.11, FS ***This series may have archival value.***

**RETENTION:**

a) Record copy. Retain until 24 years of age or 7 years after last entry, whichever is longer
b) Duplicates. Retain until obsolete, superseded or administrative value is lost.

**PATIENT RECORDS: PHARMACY (Item # 129)**

This record series consists of a patient record system maintained by all pharmacies for patients to whom new or refill prescriptions are dispensed. This series includes the patient's full name, address, telephone number, age or date of birth, gender, a list of all new or refill prescriptions from previous providers, and any comments on patient's therapy. Allergies, drug reactions, idiosyncrasies, chronic conditions, disease states, and notes on medical devices and existing conditions may also be recorded. This record may be maintained in hard copy or computerized formats. 59X-27.800, 59X-28.140, 59X-28.150, FAC.

**RETENTION:**

a) Record copy. 2 years after last entry.
b) Duplicates. Retain until obsolete, superseded or administrative value is lost.

**PATIENT TESTING: IMMUNOHEMATOLOGY RECORDS (Item # 84)**

This record series consists of the documents which record each step in the processing, testing, and reporting of patient specimens to assure the accuracy of the testing. Documentation includes all the information recorded on the test requisition plus the accession number of the specimen, the date and time of the specimen's receipt by the lab, the condition and disposition of the specimens which do not meet the lab's acceptance standards, and the records and dates of performance of each step in the patient testing leading to and including the final report. This record series is specific to immunohematology and histocompatibility records. 42 CFR 493.1101.

**RETENTION:**

a) Record copy. 5 years.
b) Duplicates. Retain until obsolete, superseded or administrative value is lost.

**PATIENT TESTS: LABORATORY COPY (Item # 83)**

This record series consists of the documents which record each step in the processing, testing, and reporting of patient specimens to assure the accuracy of testing. Documentation includes all the information recorded on the test requisition plus the accession number of the specimen, the date and time of the lab's receipt of the specimen, the condition and disposition of the specimens which do not meet the lab's acceptance criteria, and the records and dates of performance of each step of the patient testing leading to and including the final report. This series also documents the loan or referral of slides to another laboratory and is relevant to JCAHCO standard QC4.6. This retention does not apply to pathology and immunohematology testing. 42 CFR 493.1101.

**RETENTION:**

a) Record copy. 2 years.
b) Duplicates. Retain until obsolete, superseded or administrative value is lost.

**PERFORMANCE REPORTS: PROFICIENCY TESTING FACILITY (Item # 94)**

This record series consists of reports issued on each laboratory's performances for the individual Medicare, Medicaid, and CLIA-licensed specialty or sub-specialty of service after a proficiency test is performed. Duplicate copies of these reports are also sent to Health and Human Services, the laboratory which was tested, and the state survey agency. 42 CFR 493.903.

**RETENTION:**

a) Record copy. 5 years.
b) Duplicates. Retain until obsolete, superseded or administrative value is lost.

**PLANNED SPECIAL EXPOSURE: RADIOLOGY (Item # 112)**

This record series consists of records on each planned special exposure. These records may include, but are not limited to, the following: the exceptional circumstances requiring the exposure; the name of the official who authorized the exposure and a copy of the signed order; which actions were necessary; why the actions were necessary; what precautions were taken to assure that doses were maintained in accordance with standard; what individual and collective doses were expected to result in; and the dose actually received during exposure. 10D-91.474, FAC.

**RETENTION:**

a) Record copy. 1 year after termination or expiration of license.
b) Duplicates. Retain until obsolete, superseded or administrative value is lost.

**PRESCRIPTION RECORDS (Item # 64)**

This record series consists of a written prescription which is retained by the pharmacist in the pharmacy from which it is filled. The prescription includes: the full name and address of the patient; the full name and address of the prescribing practitioner and his federal controlled substance registry number; the name of the substance prescribed, its quantity and strength and the directions for its use; the prescription number; and the initials of the pharmacist and the date filled. s. 893.04, FS and 59X-28.140, FAC

**RETENTION:**

a) Record copy. 2 years.
b) Duplicates. Retain until obsolete, superseded or administrative value is lost.

**PROCESSING RECORDS: BLOOD BANK (Item # 121)**

This record series consists of blood bank records which monitor the process by which blood products are made available for use. Processing records include: blood processing, including the results and interpretation of all tests and re-tests; component preparation, including all relevant dates and times; separation and pooling of recovered plasma; the centrifugation and pooling of source plasma; and the labeling of the product including the initials of the processor. 21 CFR 606.151

**RETENTION:**

a) Record copy. 5 years.
b) Duplicates. Retain until obsolete, superseded or administrative value is lost.

**PROFICIENCY TESTING: LABORATORIES (Item # 93)**

This record series consists of documents which attest to the handling, preparation, processing, examination, and each step in the testing and reporting of results for all proficiency testing samples, including a copy of the proficiency testing program report forms used to record the test results. This series also features all documents which reflect the necessary training and technical assistance appropriate to correcting the problems associated with proficiency testing failures. 42 CFR 493.801 and .823

**RETENTION:**

a) Record copy. 2 years after event.
b) Duplicates. Retain until obsolete, superseded or administrative value is lost.

**QUALITY CONTROL RECORDS: IMMUNOHEMATOLOGY (Item # 82)**
This record series consists of all documentation which attests to the quality control requirements specified in 42 CFR 93.1203 through 493.1285. Included in this series are all records which document that the quality control samples were tested in the same exact manner as the regular patient samples. This series is only for the quality control records of immunohematology samples. 42 CFR 493.1221 and 21 CFR 606.
**RETENTION:**
a) Record copy. 5 years.
b) Duplicates. Retain until obsolete, superseded or administrative value is lost.

**QUALITY CONTROL RECORDS: LABORATORIES (Item # 81)**
This record series consists of all documentation which attests to the quality control requirements specified in 42 CFR 93.1203 through 493.1285. Included in this series are the records of each step in the processing and testing of the quality control samples to assure that the quality control samples are tested in the same exact manner as the regular patient samples. This series does not apply to testing of immunohematology samples. 42 CFR 493.1221.
**RETENTION:**
a) Record copy. 2 years.
b) Duplicates. Retain until obsolete, superseded or administrative value is lost.

**QUALITY CONTROL SURVEY: MAMMOGRAPHY FACILITY (Item # 92)**
This record series consists of the reports of the surveys conducted annually to assure that the facility meets specified quality control and equipment standards. 21 CFR 900.12.
**RETENTION:**
a) Record copy. 1 calendar year.
b) Duplicates. Retain until obsolete, superseded or administrative value is lost.

**RADIATION DETECTION INSTRUMENTATION (Item # 86)**
This record series consists of documents which record the dates and times of the calibration of radiation detection instruments as well as the name of the individual performing the calibration. These are the instruments which measure radiation levels in the environment, on humans, and objects. This series also includes any repair to the instrumentation including the date and time of inspection, the problem located, the out of service dates, and the date of its return. 59A-3.228, FAC.
**RETENTION:**
a) Record copy. 3 years.
b) Duplicates. Retain until obsolete, superseded or administrative value is lost.

**RADIATION EQUIPMENT: MINOR MAINTENANCE (Item # 87)**
This record series consists of documentation of all minor maintenance, daily function checks, and instrument calibration performed in accordance with the manufacturer's instructions on the testing equipment operated by a testing facility, hospital, or clinic. This series does not cover major repairs, parts replacement, or annual maintenance. This series is equivalent to JCAHCO standard EC1.6. 59A-6.022, FAC.
**RETENTION:**
a) Record copy. 2 years.
b) Duplicates. Retain until obsolete, superseded or administrative value is lost.

**RADIATION MONITORING RECORDS: HUMAN EXPOSURE (Item # 88)**
This record series consists of documents which record the annual doses received by individuals for whom monitoring is required as specified in 10D-91.446, FAC, and the doses received during planned special exposures, accidents, and emergency conditions. Eligible persons include adults and minors who receive in excess of their limitations in a single year and individuals entering a high or very high radiation area. When applicable, these records should contain: the deep dose equivalent to the whole body, eye dose equivalent, shallow dose equivalent to the skin and extremities, the estimated intake of radionuclides; the

**RADIATION MONITORING RECORDS: HUMAN EXPOSURE (Item # 88) CONTINUED**
committed effective dose equivalent assigned to the intake of radionuclides; the specific information used to calculate the committed dose; the total effective dose; and the total of the deep dose and committed dose to the organ receiving the highest total dose. This series also includes documents which record the radiation dose to an embryo or fetus and the expectant mother. These documents note the name of the mother, the date of treatment, the organ receiving the highest dose, and the name of the staff member performing the therapy. The Declaration of Pregnancy may be filed separately from the dosage records and contains a formal acknowledgment by the mother that she is expecting. The form gives an estimated conception date and is designed to alert the staff to pregnancy. This series also includes the results of measurements and calculations used to determine individual intakes of radioactive materials and used in the assessment of the internal dose. Surveys of radiation for the purpose of determining an individual's
dose from external sources are also included. These surveys are used in the assessment of individual dose equivalents in the absence of or in combination with individual monitoring data. 10D-91.446, 10D-91.471, 10D-91.475, 10D-91.518 and 59A-3.228, FAC.
**RETENTION:**
a) Record copy. 1 year after the termination or expiration of license.
b) Duplicates. Retain until obsolete, superseded or administrative value is lost.

**RADIATION PROTECTION PROGRAM (Item # 124)**
This record series consists of the written provisions of a radiation protection program designed to prevent unnecessary radiological exposure to humans and the environment. This series relates to JCAHCO standard QC13.1. 10D-91.470, FAC.
**RETENTION:**
a) Record copy. 1 year after termination or expiration of license.
b) Duplicates. Retain until obsolete, superseded or administrative value is lost.

**RADIOACTIVE WASTE DISPOSAL RECORDS (Item # 89)**
This record series consists of documents which record the disposal of radioactive waste and by-products by the radiology section. These records may include the date and method of disposal, the name and address of the waste hauler, the amount disposed of, and the name of the staff handling the disposal or transfer process. 10D-91.477 and 59A-3.228, FAC.
**RETENTION:**
a) Record copy. 1 year after the termination or expiration of license.
b) Duplicates. Retain until obsolete, superseded or administrative value is lost.

**RADIOACTIVE WASTE DISPOSAL RECORDS: NON-SEALED SOURCE (Item #113)**
This record series consists of reports which document the disposal of any radioactive material which is not a sealed source and has a physical half life of less than 90 days. This report contains the date of disposal, the date the material was placed in storage, the radionuclides disposed of, the model and serial number of the survey instrument used, the background dose rate, the container's surface radiation dose rate, and the name of the individual performing the disposal. 10D-91.465, 10D-91.477, and 10D-91.732, FAC.
**RETENTION:**
a) Record copy. 3 years.
b) Duplicates. Retain until obsolete, superseded or administrative value is lost.

**REQUISTIONS: LABORATORY TESTS (Item # 95)**

This record series consists of all requisitions authorizing a laboratory to perform tests on a sample. These requisitions may be in an electronic or written format. Included in a requisition are the patient's name or identification number, the name or identifier of who ordered the test, the date and time of the specimen collection, the source of the specimen, the patient's gender and age or date of birth, and pertinent clinical information. For pap smears the requisition also requires the last date of menstruation, history of abnormal smears, treatment of biopsy, and risk factors for cervical cancer. The record copy is retained by a public laboratory. Duplicates may be in the Patient Medical Record. 42 CFR 493.1101.

**RETENTION:**

a) Record copy. 2 years.
b) Duplicates. Retain as long as the item it relates to.

**RESIDENT CONTRACTS: ASSISTED LIVING FACILITIES (Item # 109)**

This record series consists of contracts signed by the resident or resident's guardian which place the resident in the care of the facility. The contract would contain provisions specifically setting forth the services and accommodations to be provided by the facility to the including extended congregate care services, limited mental health or nursing services. The contract will also list the basic daily, weekly, monthly, and annual charges or rates and any extra services provided and their fees. Payment procedures, rate increase policies, notices of religious affiliations, and written bed hold policies and termination agreements are also part of the contract. 58A-5.024 FAC.

**RETENTION:**

a) Record copy. 5 fiscal years after completion of contract provided applicable audits have been resolved.
b) Duplicates. Retain until obsolete, superseded or administrative value is lost.

**RESIDENT RECORDS: ASSISTED LIVING FACILITIES (Item # 110)**

This record series consists of documentation relating to the care and contractual obligations of the facility to the resident. Included in this series are documents appointing the resident's guardian, establishing a power-of-attorney, demographic data, therapeutic diets, and a healthcare provider's name and address. Medical records are maintained separately and take the retention period of the patient medical record. 58A-5.024, FAC ***This series may have archival value.***

**RETENTION:**

a) Record copy. 1 year after departure or death.
b) Duplicates. Retain until obsolete, superseded or administrative value is lost.

**RISK MANAGEMENT RECORDS: INTERNAL (Item # 69)**

This record series consists of internal risk management records including: education and training of all non-physician employees, an analysis of patient grievances; review of incident reports; and minutes of the risk management committee. This record series does not cover the hospital's copy of adverse incident reports which are required to be sent to the Agency for Health Care Administration or the required annual report.
s. 95.11 and 395.0197, FS

**RETENTION:**

a) Record copy. 7 calendar years.
b) Duplicates. Retain until obsolete, superseded or administrative value is lost.

**RUN REPORTS: EMERGENCY** **(Item # 70)**

This record series consists of a report on patients who have been revived, or attempted to be revived, by the administration of drugs, both intercardiac and intravenously, and by using counter-shock treatment as well as all other patients who accepted service from an EMT, EMS or Air-Medical Provider, or a paramedic. Run reports will include patient's name, home address, age or date of birth, sex and race; call identification number, unit number of responding vehicles; transporting vehicle, if applicable; location of scene or incident; location of patient and destination of each call. The record copy of the run report is held by the service provider and a duplicate is sent to the Dept. of Health, formerly known as the HRS EMS Office. 10D-66.060, FAC and s. 95.11, FS See also "RUN REPORTS: NON-EMERGENCY" in the GS8.

**RETENTION:**

a) Record copy. 7 years after last entry.
b) Duplicates. Retain until obsolete, superseded or administrative value is lost.

**SCHEDULES:MEDICAL PERSONNEL** **(Item # 126)**

This record series consists of work schedules for medical personnel including the nursing staff, physicians, medical aides, and support staff who provide medical treatment including phlebotomists. These schedules may be maintained on a daily, weekly, monthly or bimonthly basis. The record copy is located in the administrator's office for the particular department or with the individual in charge of staffing. Duplicates may be found throughout the agency.

**RETENTION:**

a) Record copy. 7 years.
b) Duplicates. Retain until obsolete, superseded or administrative value is lost

**SURVEYS: RADIOLOGY** **(Item # 106)**

This record series consists of surveys which are necessary to evaluate radiation levels, concentrations or quantities of radioactive materials, and potential radioactive hazards that could be present. This series also includes surveys of physical radiation for the purpose of determining whether each sealed source is in its shielded position prior to securing the radiographic device, storage container, or source changes in a storage area. The entire device is surveyed including the source guide tube. 10D-91.445 and 10D-91.471, FAC

**RETENTION:**

a) Record copy. 3 years.
b) Duplicates. Retain until obsolete, superseded or administrative value is lost.

**TEST PROCEDURES: DISCONTINUED** **(Item # 103)**

This record series consists of a copy of each test procedure with the dates of its initial use and discontinuance. The procedure may explain, but is not limited to, the methodology of the test, the results sought, the positions who perform the test, possible side effects, and any necessary equipment. 59A-6.022, FAC and s. 95.11, F.S.

**RETENTION:**

a) Record copy. 4 years after discontinued.
b) Duplicates. Retain until obsolete, superseded or administrative value is lost.

**TESTING: ENTRY CONTROL DEVICES** **(Item # 114)**

This record series consists of documents which record the testing of the entry control devices to secured areas, housing high levels of radiation. These records must include the date, time and results of each test. Testing shall be conducted prior to initial operation and a schedule of periodic testing for the entry control and warning systems will be followed by the radiology section. 10D-91.449 and 10D-91.478, FAC

**RETENTION:**

a) Record copy. 3 years.
b) Duplicates. Retain until obsolete, superseded or administrative value is lost.

**TESTING: SEALED SOURCES** **(Item # 105)**

This record series consists of documentation on the testing of sealed sources of radiation by the radiology department for leaks or contamination. These records would contain the date and time of the test, the name of who performed the test, the sources tested, the results of the test, the levels of radiation found, and the actions taken by staff. 10D-91.472, FAC

**RETENTION:**

a) Record copy. 3 years.
b) Duplicates. Retain until obsolete, superseded or administrative value is lost.

**TISSUE TRACKING SYSTEM** **(Item # 99)**

This record series consists of all documents in the centralized tracking system which records the receipt and disposition of all organs and tissues transplanted within the hospital. At a minimum, the system will include the following records: the organ or tissue type; the donor id number; the name and license number of the procurement or distribution facility which supplied the tissue/organ; recipient name and id number; name of transplanting doctor; date the organ/tissue was received by the hospital; and the date of the transplant. This information may be provided quarterly to an organ or tissue procurement service. 59A-3.214, FAC ***This series may have archival value.***

**RETENTION:**

a) Record copy. Permanent.
b) Duplicates. Retain until obsolete, superseded or administrative value is lost.

**TRAINING & LICENSE RECORDS: RADIOLOGY** **(Item # 100)**

This record series consists of the credentials, licenses, and certifications of each person providing diagnostic and therapeutic radiation, imaging, and nuclear medicine services including formal training, on the job education, and continuing educational credits. 59A-3.228, FAC and s. 95.11, FS

**RETENTION:**

a) Record copy. 7 years after separation or termination of employment.
b) Duplicates. Retain until obsolete, superseded or administrative value is lost.

**UTILIZATION LOGS: RADIOLOGY** **(Item # 117)**

This record series consists of current logs which show for each source of radiation a detailed description or the make and model number for the sources or the storage container in which the sealed source is located, the identity of the radiographer to whom the source is assigned, and the locations and dates of its use. 10D-91.509 and 59A-3.228, FAC

**RETENTION:**

a) Record copy. 2 years.
b) Duplicates. Retain until obsolete, superseded or administrative value is lost.

**X-RAY FILMS** **(Item # 78)**

This record series consists of developed x-ray film which may have been interpreted by a radiologist. Interpretations of these films may be found in the Patient Medical Record. Mammograms of returning patients are included in this series. Mammograms of one-time-visitors are located in Item #90, Mammograms.

**RETENTION:**

a) Record copy. 7 years.
b) Duplicates. Retain until obsolete, superseded or administrative value is lost.

**X-RAY LOGS** **(Item # 98)**

This record series consists of a log for each x-ray device which records the name of the patient, the type of examination, the dates of the exam, and the technician performing the service. When the patient or film must be provided with human auxiliary support, the name of the human holder shall be recorded as well. 10D-91.603 and 59A-3.228, FAC

**RETENTION:**

a) Record copy. 7 years after last entry.

b) Duplicates. Retain until obsolete, superseded or administrative value is lost.

## Cross Reference

### A

AMBULANCE RECORDS (GENERAL)
- INVENTORY RECORDS: DRUGS (item #127)
- MINUTES: AIR AMBLUANCE SAFETY COMMITTEE (item #125)
- RUN REPORTS: EMERGENCY (item #70)
- *SEE ALSO GS8, ITEM #39, RUN REPORTS: NON-EMERGENCY*

ANESTHESIA RECORDS
- PATIENT MEDICAL RECORD (items #80, 130, 133)

APPOINTMENT BOOKS: CLINIC
- CALENDARS (GS1, item #89)

AUTOPSY RECORDS
- PATIENT MEDICAL RECORD (items #80, 130, 133)

### B

BLOOD BANK (GENERAL)
- BLOOD BANK RECORDS (item #122)
- PROCESSING RECORDS (item #121)

BLOOD DONOR HISTORY RECORDS
- PATIENT MEDICAL RECORD (items #80, 130, 133)

BLOOD USAGE RECORDS: TRANSFUSIONS
- PATIENT MEDICAL RECORD (items #80, 130, 133)

BONE MARROW TEST REPORTS
- PATIENT MEDICAL RECORD (items #80, 130, 133)

### C

CENSUS RECORDS: REPORTS (ANNUAL) (MONTHLY) (DAILY)
- ADMISSIONS REPORTS: STATISTICAL (item # 2)

CHILD ABUSE REPORTS: HOSPITAL COPY
- PATIENT MEDICAL RECORD (items #80, 130, 133)

CLINICAL PATHOLOGY LOGS
- FINAL TEST REPORTS: PATHOLOGY (item #85)

CLINICAL PATHOLOGY REPORTS: PATIENT
- PATIENT MEDICAL RECORD (items #80, 130, 133)

CLINICAL PATHOLOGY REPORTS: OUTPATIENT
- PATIENT MEDICAL RECORD (items #80, 130, 133)

COMMUNICATIONS TAPE RECORDINGS: EMERGENCY MEDICAL SERVICES
- RADIO LOGS: COMMUNICATIONS (GS8, item 33)

COMUNICABLE DISEASE REPORTS: HOSPITAL COPY
- PATIENT MEDICAL RECORD (items #80, 130, 133)

CYTOLOGY REPORTS
- PATIENT MEDICAL RECORD (items #80, 130, 133)

### D

DIALYSIS RECORDS
- PATIENT MEDICAL RECORD (items #80, 130, 133)

DIET COUNSELING RECORDS
- PATIENT MEDICAL RECORD (items #80, 130, 133)

DIET RECORDS: INDIVIDUAL
- PATIENT MEDICAL RECORD (items #80, 130, 133)

DRUG RECORDS: PATIENT
- PATIENT MEDICAL RECORD (items #80, 130, 133)

DRUG RECORDS: REQUISITIONING/DISPENSING
- INVENTORY RECORDS: DRUG (item # 127)

## E

ELECTROCARDIOGRAM TRACINGS
- EKG/EEG/FETAL HEART MONITOR STRIPS (item #118)
- PATIENT MEDICAL RECORD (items #80, 130, 133)

ELECTROENCEPHALOGRAM TRACINGS
- EKG/EEG/FETAL HEART MONITOR STRIPS (item #118)
- PATIENT MEDICAL RECORD (items #80, 130, 133)

## F

FETAL HEART MONITOR STRIPS
- EKG/EEG/FETAL HEART MONITOR STRIPS (item #118)
- PATIENT MEDICAL RECORD (items #80, 130, 133)

## H

HEALTH EXAMINATION RECORDS: FOOD HANDLERS
- HEALTH EXAMINATION RECORDS: ROUTINE PERSONNEL (GS1, item # 212)

## I

INCIDENT REPORTS: SUMMARY AND REVIEW
- RISK MANAGEMENT RECORDS: INTERNAL (item #69)

INCINERATOR RECORDS
- ON-SITE INCINERATOR RECORDS (item #97)

INFANT SCREENING TEST REPORTS (QUARTERLY)
- PATIENT MEDICAL RECORD (items #80, 130, 133)

INHALATION THERAPY RECORDS
- PATIENT MEDICAL RECORD (items #80, 130, 133)

IMMUNIZATION RECORDS
- PATIENT MEDICAL RECORD (items #80, 130, 133)

INVENTORY RECORDS: DRUGS
- INVENTORY RECORDS: DRUG (item #127)

## L

LABORATORY LOGS
- PATIENT TESTS: LABORATORY (item # 83)

LABORATORY QUALITY CONTROL RECORDS
- QUALITY CONTROL RECORDS: LABORATORIES (item # 81)

LABORATORY RECORDS (GENERAL)
- PATIENT TESTING: IMMUNOHEMATOLOGY (item #84)
- PATIENT TEST: LABORATORY COPY (item #83)
- FINAL TEST REPORT: PATHOLOGY (item #85)
- PERFORMANCE REPORT: PROFICIENCY TESTING FACILITY (item #94)
- PROFICIENCY TESTS: LABORATORY (item #93)
- QUALITY CONTROL RECORDS: IMMUNOHEMATOLOGY (item #82)
- QUALITY CONTROL RECORDS (item #81)
- REQUSITION: LABORATORY TESTS (item #95)
- TEST PROCEDURES: DISCONTINUED (item #103)

LABORATORY TEST REPORTS
- PATIENT TESTS: LABORATORY COPY (item #83)

## M

MAMMOGRAPHY
- COMPLAINT RECORDS: MAMMOGRAPHY FACILITY (item #91)
- MAMMOGRAMS: SINGLE VISIT (item #90)
- QUALITY CONTROL RECORDS: MAMMOGRAPHY FACILITY (item #92)
- X-RAY FILMS (item #78)

MEDICAL RECORDS: (PATIENT) EMERGENCY ROOM
- PATIENT MEDICAL RECORD (items #80, 130, 133)

MEDICAL RECORDS: (PATIENT) INPATIENT
PATIENT MEDICAL RECORD (items #80, 130, 133)

MEDICAL RECORDS: (PATIENT) OUTPATIENT/CLINIC
PATIENT MEDICAL RECORD (items #80, 130, 133)

## N

NUCLEAR MEDICINE SERVICES RECORDS
PATIENT MEDICAL RECORD (items #80, 130, 133)

NURSING CARE PLANS: DAILY
SCHEDULES: MEDICAL PERSONNEL (item #126)

NURSING PLANS: DEPARTMENTAL
MANUALS, DIRECTIVES, POLICIES, PLANS: SUPERSEDED (item #120)

## O

OCCUPATIONAL THERAPY RECORDS
PATIENT MEDICAL RECORD (items #80, 130, 133)

## P

PATHOLOGY REPORTS: SURGICAL TISSUE
FINAL TEST REPORTS: PATHOLOGY (item #85)

PHARMACY RECORDS
INVENTORY RECORDS: DRUG (item #127)
PATIENT RECORD: PHARMACY (item #129)
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PHYSICAL THERAPY RECORDS
PATIENT MEDICAL RECORD (items #80, 130, 133)

PSYCHIATRIC REPORTS
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RADIATION EXPOSURE RECORDS: PERSONNEL
RADIATION MONITORING RECORDS: HUMAN EXPOSURE (item # 88)

RADIATION MONITORING RECORDS: EQUIPMENT
MAINTENANCE INSPECTION: RADIOGRAPHIC DEVICES (item # 116)

RADIATION PROTECTION PROGRAM RECORDS
AUDITS: RADIATION PROTECTION PROGRAM (item #108)

RADIOACTIVE MATERIALS RECORDS
RADIOACTIVE WASTE DISPOSAL RECORDS (items #89, 113)

RADIOLOGY RECORDS (GENERAL)
INSPECTIONS (item #101)
INVENTORY: SEALED SOURCES (item #115)
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MEASUREMENTS/CALCULATIONS; ENVIRONMENTAL EXPOSURE (item #123)
MONITORING RECORDS (item #104)
PLANNED SPECIAL EXPOSURE (item #112)
RADIATION DETECTION INSTRUMENTATION (item #86)
RADIATION EQUIPMENT: MINOR MAINTENANCE (item #87)
RADIATION MONITORING RECORDS (item #88)
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TESTING: ENTRY CONTROL DEVICES (item #114)
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TRAINING AND LICENSES: RADIOLOGISTS (item #100)
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RISK MANAGEMENT
- INCIDENT RECORDS (item #40)
- INFECTION CONTROL PROGRAM: REPORTS (item #131)
- RISK MANAGEMENT RECORDS: INTERNAL (item #69)

## S

SOCIAL SERVICES CASE FILES
- PATIENT MEDICAL RECORD (items #80, 130, 133)

SPECIMEN LOGS: PATHOLOGY
- FINAL TEST REPORTS: PATHOLOGY (item # 85)

SPEECH THERAPY RECORDS
- PATIENT MEDICAL RECORD (items #80, 130, 133)

SURGICAL INFECTION INVESTIGATION REPORTS
- INFECTION CONTROL PROGRAM: REPORTS (item # 4)

## U

UTILIZATION REVIEW PLANS
- MANUALS, DIRECTIVES, POLICIES, PLANS: SUPERSEDED (item #120)

## X

X-RAY INTERPRETATION REPORTS
- PATIENT MEDICAL RECORD (items#80, 130, 133)