

1 10A NCAC 14E .0305 is amended with changes as published in NCR 29:11, pp. 1290-1298 as follows:

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3 **10A NCAC 14E .0305 MEDICAL RECORDS**

4 (a) A complete and permanent record shall be maintained for all patients ~~including: including the date and time of~~
5 ~~admission and discharge; the full and true name; address; date of birth; nearest of kin; diagnoses; duration of~~
6 ~~pregnancy; condition on admission and discharge; referring and attending physician; a witnessed, voluntarily signed~~
7 ~~consent for each surgery or procedure and signature of the physician performing the procedure; and the physician's~~
8 ~~authenticated history and physical examination including identification of pre-existing or current illnesses, drug~~
9 ~~sensitivities or other idiosyncrasies having a bearing on the operative procedure or anesthetic to be administered.~~

10 (1) the date and time of admission and discharge;

11 (2) the patient's full and true name;

12 (3) the patient's address;

13 (4) the patient's date of birth;

14 (5) the patient's emergency contact information;

15 (6) the patient's diagnoses;

16 (7) the patient's duration of pregnancy;

17 (8) the patient's condition on admission and discharge;

18 (9) a [witnessed,] voluntarily-signed consent for each surgery or procedure and signature of the
19 physician performing the [procedure,] procedure witnessed by a family member, other patient
20 representative, or facility staff member;

21 (10) the patient's history and physical examination including identification of pre-existing or current
22 illnesses, drug sensitivities or other idiosyncrasies having a bearing on the procedure or anesthetic
23 to be administered; and

24 (11) documentation that indicates all items listed in Rule .0304(d) of this Section were provided to the
25 patient.

26 (b) All other pertinent information such as pre- and ~~post-operative~~ post-procedure instructions, laboratory report,
27 drugs administered, report of ~~operation~~ abortion procedure, and follow-up ~~instruction~~ instruction, including family
28 planning ~~advice~~ advice, shall be recorded and ~~authenticated.~~ authenticated by signature, date, and time.

29 (c) If Rh is negative, the significance shall be explained to the patient and so recorded. The patient in writing may
30 reject Rh immunoglobulin, ~~or accept the appropriate desensitization material.~~ A written record of the patient's
31 decision shall be a permanent part of her medical record.

32 (d) An ultrasound examination shall be performed and the ~~results posted~~ results, including gestational age, placed in
33 the patient's medical record for any patient who is scheduled for an abortion procedure.

34 (e) The ~~facility~~ clinic shall maintain a daily procedure log of all patients receiving abortion services. This log shall
35 contain at least the following: patient name, estimated length of gestation, type of procedure, name of physician,
36 name of RN on duty, and date and time of procedure.

37 (1) the patient name;

- 1 (2) the estimated length of gestation;
- 2 (3) the type of procedure;
- 3 (4) the name of physician;
- 4 (5) the name of Registered Nurse on duty; and
- 5 (6) the date and time of procedure.

6 (f) Medical records shall be the property of the facility clinic and shall be preserved or retained in the State of North
7 Carolina for a period of not less than at least 20 10 years from the date of the most recent discharge, unless the client
8 is a minor, in which case the record must be retained until three years after the client's 18th birthday, regardless of
9 change of facility clinic ownership or administration. Such medical records shall be made available to the Division
10 upon request and shall not be removed from the premises where they are retained except by subpoena or court order.

11 (g) The facility clinic shall have a written plan for destruction of medical records to identify information to be
12 retained and the manner of destruction to ensure confidentiality of all material.

13 (h) Should a facility clinic cease operation, arrangements shall be made for preservation of records for at least 20 10
14 years. The facility clinic shall notify the Division, in writing, concerning the arrangements. send written notification
15 to the Division of these arrangements.

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17 *History Note: Authority G.S. 14-45.1(a); [~~G.S. 90-21.83;~~] 143B-10; S.L. 2013-366 s.4(c);*
18 *Eff. February 1, 1976;*
19 *Readopted Eff. December 19, 1977;*
20 *Amended Eff. October 1, 2015; July 1, 1994; December 1, 1989.*