

10A NCAC 14E .0305 MEDICAL RECORDS

- (a) A complete and permanent record shall be maintained for all patients including:
- (1) the date and time of admission and discharge;
 - (2) the patient's full and true name;
 - (3) the patient's address;
 - (4) the patient's date of birth;
 - (5) the patient's emergency contact information;
 - (6) the patient's diagnoses;
 - (7) the patient's duration of pregnancy;
 - (8) the patient's condition on admission and discharge;
 - (9) a voluntarily-signed consent for each surgery or procedure and signature of the physician performing the procedure witnessed by a family member, other patient representative, or facility staff member;
 - (10) the patient's history and physical examination including identification of pre-existing or current illnesses, drug sensitivities or other idiosyncrasies having a bearing on the procedure or anesthetic to be administered; and
 - (11) documentation that indicates all items listed in Rule .0304(d) of this Section were provided to the patient.
- (b) All other pertinent information such as pre- and post-procedure instructions, laboratory report, drugs administered, report of abortion procedure, and follow-up instruction, including family planning advice, shall be recorded and authenticated by signature, date, and time.
- (c) If Rh is negative, the significance shall be explained to the patient and so recorded. The patient in writing may reject Rh immunoglobulin. A written record of the patient's decision shall be a permanent part of her medical record.
- (d) An ultrasound examination shall be performed and the results, including gestational age, placed in the patient's medical record for any patient who is scheduled for an abortion procedure.
- (e) The clinic shall maintain a daily procedure log of all patients receiving abortion services. This log shall contain at least the following:
- (1) the patient name;
 - (2) the estimated length of gestation;
 - (3) the type of procedure;
 - (4) the name of physician;
 - (5) the name of Registered Nurse on duty; and
 - (6) the date and time of procedure.
- (f) Medical records shall be the property of the clinic and shall be preserved or retained in the State of North Carolina for a period of not less than 10 years from the date of the most recent discharge, unless the client is a minor, in which case the record must be retained until three years after the client's 18th birthday, regardless of change of clinic ownership or administration. Such medical records shall be made available to the Division upon request and shall not be removed from the premises where they are retained except by subpoena or court order.
- (g) The clinic shall have a written plan for destruction of medical records to identify information to be retained and the manner of destruction to ensure confidentiality of all material.
- (h) Should a clinic cease operation, arrangements shall be made for preservation of records for at least 10 years. The clinic shall send written notification to the Division of these arrangements.

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