HEALTH SERVICES BULLETIN NO. 15.12.03

SUBJECT: HEALTH RECORDS

EFFECTIVE DATE: 08/02/13

I. PURPOSE:

This health services bulletin (HSB) establishes health record standards for the Department of Corrections (DC. The health record is initiated during the reception process and shall contain all information of health care provided during the prison term. A comprehensive health record provides a current, concise and comprehensive account of each inmate's health history. (ACA 4396)

NOTE: Technical assistance requests or specific questions regarding this health services bulletin or health record management should be directed to the Regional Health Services Manager, or in matters relating to the use and disclosure of protected health information, the Office of Health Services Privacy Officer.

II. DEFINITIONS:

A. An **active health record** is one maintained and kept current throughout the present incarceration of an inmate with the Department. An active health record is comprised of the current record (inclusive of infirmary record, dental record, and mental health testing) and all thinned volumes of the current incarceration.

B. The **current volume** of the active health record is the volume that is presently being used for documentation.

C. The **designated record set** refers to the inmate's medical, mental health, and dental files (including all information in the green, blue, and orange jackets), and Reception Medical Center Hospital's inpatient hospital file that are maintained by the Department.

D. An **inactive health record** is one maintained by the Department's Reception and Medical Center record archives once an inmate's custody has ended (end of sentence [EOS]).

E. **Contracted staff** refers to staff that are hired by an organization contracted to provide health care services in Florida Department of Corrections' institutions.

III. RESPONSIBILITIES:

A. These standards and responsibilities apply to both Department staff and Contracted staff.

B. Chief Health Officer—The primary responsibility for an adequate health record rests with the institutional Chief Health Officer.

C. Physicians, Physician Assistants (PAs), Dentists, Advanced Registered Nurse Practitioners (ARNPs), Nurses, Correctional Medical Technicians-Certified (CMT-C), Unit Treatment and Rehabilitation Specialists (UTRS), Psychiatrists, Psychologists, and other appropriate allied health care staff members - are responsible for recording

observations pertinent to the patient's care and treatment at the time service is rendered. In no event shall the health record remain incomplete beyond thirty (30) days after release of the inmate from the Department's custody. An inmate's health record shall be available each time s/he appears for a health care encounter. Lack of a health care record shall not interfere with providing health care to the inmate. The provider shall legibly document each entry in black ink; enter the date and military time and sign his/her name and title after each entry (e.g., John Jones, M.D.).The use of correction fluid is not allowed. Highlighting (yellow only) may be used on DC4-701A *Medication and Treatment Record (MAR)* to indicate that an order has been discontinued or changed. Following each entry, the provider's signature and stamp shall be used. When the provider has not received a stamp, the name, title, institution and vendor company name (contracted staff only) shall be printed. The stamp shall include the health care provider's name, title, and institutional identification.

D. All Health Services Staff - The responsibility for initiating, completing, safe storing, and ensuring confidentiality of health records rests with health services personnel, including compliance with applicable DC procedures, rules and health services bulletins, other appropriate directives, and all professional standards of practice. Health care practitioners will return health records to the Medical Record Department when they have finished with the records, in accordance with Section E, Standard 5 below.

E. Senior/Health Services Administrator (S/HSA)—The S/HSA is directly responsible for the performance of the institution's medical records unit. The HSA shall ensure that medical records staff maintain standards as identified in Section III.D of this health services bulletin.

F. Health Information Specialist (HIS)—The Health Information Specialist is the clinical support professional responsible for overall maintenance of institutional health record services. (If the health care facility does not have a full- or part-time HIS, the HSA or Regional Health Services Manager (RHSM) shall assign this responsibility to a qualified employee in coordination with the Chief Health Officer.)

The HIS's primary responsibility is ensuring all medical records are complete prior to filing the records. A system shall be developed to identify records requiring additional information (e.g., signature) and the records shall be kept separate until complete. It is the responsibility of the HIS to ensure staff compliance.

Each institutional HIS shall ensure that all health records meet the following standards:

Standard 1—The health record shall contain sufficient information to clearly identify the inmate, chronologically display any diagnoses/illnesses, and reflect the treatment provided. All health record entries are complete, legible, authenticated, accurate and promptly recorded.

Standard 2—All health records, at all times, shall be maintained confidential, secure, and current with access limited to those who have a valid need to know, and such records shall be readily available to authorized users according to the HIPAA Privacy Rule, 45 CFR

Subparts 160 and 164; Florida Statutes 945.10 and 456.057, Florida Administrative Code 33-401.701 and 33-601.901, and departmental procedure 102.006 (HIPAA privacy policy). (ACA 4396) (ACA 4414)
Standard 3—The health record maintenance shall be under the supervision of a qualified health record practitioner.

Standard 4—The medical records area will be audited on a quarterly basis for misfiled/missing records (both active and inactive record areas).

Standard 5—All records are returned to the medical record area when charting is completed and at the close of business each day. Health records are never left or filed in an unsecured area that is unattended by health services personnel (i.e., on carts/bins in hallways, offices, on desks/counters, etc).

Standard 6—The medical record area is safeguarded from unauthorized entry and the room will not be used for purposes other than record control/storage. Health records are protected from alterations, tampering, defacement, and loss through the use of security locks and adequate staff coverage.

Standard 7—All clinical information significant to inmate health is filed in the health record within seventy-two (72) hours of receipt.

Standard 8—Health records are stored separately from other institutional record files (e.g., classification master file). (ACA 4396)

Standard 9—Current health records shall be available each time the inmate appears for any clinical service. Additional volumes shall be made available upon provider request.

Standard 10—No food or drink is permitted in medical records documentation areas.

IV. COMPUTER-ASSISTED RECEPTION PROCESS (CARP)

A. The computer assisted reception process (CARP), is the automated mechanism for the collection of information on all inmates received into departmental custody. Once an inmate enters the reception process, CARP automatically downloads existing data maintained statewide on the Offender Based Information System (OBIS). CARP tracks all inmate health services encounters and generates related reports and health record jacket forms.

B. Upon movement of the inmate from the reception center to a permanent institution, CARP generates a series of forms that are placed in the permanent record. **It is the responsibility of the reception center HIS to ensure that all required CARP documents are in the record prior to transfer.**

C. All CARP generated DC-approved forms reflect corresponding DC4-form series number and name/title. These forms do not require staff signatures because of the sign-on/access

code built into CARP's security system, except for DC4-760A which does require a staff signature.

D. Three (3) work sheets are generated by CARP and are printed with the final chart. The forms are:

Chronological Encounter Log
Miscellaneous Procedure/Action/Referral
Mental Health Encounter Log

The receiving institutional HIS shall discard these three (3) worksheets after verification of all appointments in OBIS.

V. PREPARING HEALTH RECORD FOLDERS/FORMS

A. Health Record Jacket

1. The health record jacket (including dividers/sub-dividers) shall be initiated immediately upon receipt of an inmate at a reception center using the departmental standardized health record forms:

* DC4-745 Outpatient Medical and Mental Health (Green Jacket)
* DC4-743 Outpatient Health Record Dividers
* DC4-743A Mental Health Sub-dividers

2. The following instructions apply to all health records and forms. Future filing and handling of these records depend upon this initial action. It is of primary importance that the folder is properly completed with accurate (legible) information secured from the sentencing data.

a. With a black permanent pen, print the last name, first name, middle initial, race/sex and six (6) digit DC number of the inmate in the spaces provided along the top of the folder at the reception center only. If other known aliases apply to this commitment, each shall be recorded inside the back jacket panel as AKA underneath the true commitment name.

b. Number the folders according to the inmate six (6) digit DC number. Print the inmate number in the space provided at the top. The use of standardized color coded numerical tans for side numbers is mandatory and such is to be used at all institutions/reception centers.

c. Allergies shall be identified by checking the appropriate yes or no box on the front of the health record. The specific allergy shall be recorded in red on the DC4-730.

d. No florescent color is to be used on any medical jacket.

e. When a Do Not Resuscitate (DNR) form is in effect, a blank red removable sticker shall be placed between allergy and the DC seal. (No information is to be placed on the sticker. A DNR stamp cannot be placed on the outside of the record**)**.

f. If the DNR directive is rescinded, the **nurse** noting the order will remove the sticker and draw a line through the DNR on the problem list noting the date of the rescinded order.

g. Any stickers used by institutions (e.g., RMC) for identification of in-house processes shall be removable and will be removed from the record prior to transfer to another institution**.**

B. Inmate/Institution Identification

1. Each form and document filed in the health record shall contain minimum inmate identification, including: name, DC number, date of birth, race/sex and institutional name. This identification data shall be placed at the bottom left corner of each form used in the health record (just above the DC-approved form number).

2. The following two (2) forms shall carry institutional identification via staff provider stamps when adding diagnoses and during the initial reception processing:

a. DC4-730 *Problem List*
b. DC4-711C *Authorization for Health Evaluation and Treatment*

C. Filing Diagnostic Reports

The treating facility's name shall be identified on all laboratory/pathology, X-ray, and EKG reports. All laboratory/pathology, X-ray and EKG, and any other diagnostic reports will be reviewed, initialed and stamped by the physician/dentist or clinical associate prior to filing in the health record.

D. Maintaining Health Records

1. When an inmate's health record is removed from medical records a properly completed charge out system shall be used. Minimum requirements of a charge-out system shall include:

a. Date record was pulled.

b. Name and DC number of the record pulled.

c. Name and service area (or title of staff person who requested the record).

2. The procedure shall include notification to medical records staff by the current record holder each time a record is passed to another party before returning it to medical records unit.

E. How to Thin Outpatient and Inpatient Health Records

1. It is the responsibility of the HIS to ensure that the medical record jackets are in good condition and that the size of the contents is manageable. As record volumes expand, there is a need to purge the medical record jacket by thinning its contents. Thinning may result in additional record volumes. Volume #1 is always the oldest of active data.

2. Interim volumes shall be identified by Roman Numerals (e.g., I, II, III etc.). The consecutive numbers will include both inpatient and outpatient records with the current volume being the highest number. (Reception and Medical Center [RMC] hospital records will be kept at RMC and copies of hospital discharge summaries and other pertinent information placed in the active record.)

3. Records that are obviously too bulky to easily manage or show signs of forms being damaged due to record size will be thinned in accordance with the guidelines established below.

4. No material removed from either an outpatient or inpatient health record may be discarded or destroyed.

5. All thinned records shall be placed in a new applicable jacket folder, complete with the appropriate dividers/sub-dividers (Inpatient or Outpatient).

6. On the left inside jacket cover on a blank sheet, the HIS shall write (a rubber stamp is acceptable): See Vol. #II (#III, #IV, etc.) for current health status. This volume contains record entries from mo./yr. to mo./yr. On the right side of the jacket on DC4-701 as an incidental entry, the HIS shall write:

Record format and contents reviewed and thinned:

Date _____ By (Stamp) _____

F. Thinning the **Outpatient Medical and Mental Health** Record

1. The following information shall remain in the current volume after thinning:

a. Labs:

(1) Baselines and the last three (3) results of the same lab test within the past year.

(2) Baselines and the most current results if drawn prior to the past year.
(3) Reception center labs.
(4) First positive HIV/Western Blot test.

b. EKG: Baseline and most recent.

c. EEG: Baseline and most recent.

d. Current or most recent
(1) DC4-643A *Individualized Service Plan*
(2) DC4-643B *Individualized Service Plan Review* (Rescinded- form may be present in records prior to August 23, 2012)
(3) DC4-729 *Behavioral Risk Assessment*
(4) DC4-643C *Biopsychosocial Assessment* (BPSA)
(5) DC4-655 *Psychiatric Evaluation*
(6) DC4-545 *Series for Psychotropic Medication*
(7) DC4-653 *AIMS*
(8) DC4-663 *Consent to Mental Health Evaluation*
(9) DC4-647 *Sex Offender Screening*

e. All discharge summaries (copies) (infirmary, TCU/CSU, CMHI) for the past two (2) years or the three most recent discharges from each area.

f. Additional documents that are to remain in the current record are as follows:
(1) DC4-730 *Problem List*
(2) DC4-710 *Communicable Disease Record*
(3) DC4-710A *Immunization Record*
(4) Last four (4) chronic illness clinic notes, including associated DC4-770 Clinic Flow Sheet(s)
(5) Three (3) months of progress notes (e.g., DC4-701s and Nursing Protocol forms). If keeping this number increases the record size excessively, keep as many of the most recent as can be accommodated and remain within the thickness guidelines inclusive of other required documents.
(6) Most current transfer summaries DC4-760A.
(7) All current consents and refusals.
(8) Do not resuscitate (DNR)
(9) Current diet order
(10) Results of HIV testing
(11) Record of HIV counseling
(12) DC4-706 *Health Services Profile* – most current profile
(13) Three (3) months of MARs (DC4-701As) (excluding the one currently in the MAR book).
(14) Any consults, evaluations, etc. performed in the past three (3) months.

(15) Additional documents may be maintained in the current record if required for inmate care continuity.
(16) One (1) year current prescriptions
(17) DC6-128 *Close Management Referral Assessment*
(18) DC4-644 *Intake Psychological Screening Report*
(19) DC4-646 *Initial Suicide Profile*
(20) DC4-659 *Adaptive Behavior Checklist*

G. Thinning the **Medical Inpatient** Health Record

1. More than one infirmary admission can be placed in a jacket. Dividers will be placed between admissions.

2. The Medical Records staff will survey the inpatient hospital or infirmary patient charts on a weekly basis for bulkiness. See E.3. above.

3. The following documentation is to remain in the newly thinned medical inpatient record:
   a. All admitting documentation (e.g., Admission H&P, Nursing Admission Evaluation, Demographic sheet, lab work, EKG, Wound evaluation, etc.)

   b. 1 full month of the following documentation:
      (1) Physician's Order Sheets (DC4-714B)
      (2) Physician's progress notes/incidental notes
      (3) Patient graphs
      (4) MARs
      (5) Labs, x-rays, EKGs, etc.
      (6) Wound/skin care forms
      (7) Nurses' Daily Evaluation notes and incidental notes

   c. All consults

   d. All surgical documents, including biopsy reports

   e. Most recent consents and refusals

   f. Do Not Resuscitate (DNR) form

   g. Results of HIV testing

4. Note on the front of the chart the date the chart was thinned (e.g., Medical Record Thinned 05/26/12).

H. Thinning the **Mental Health Inpatient** Record

1. DC4-714B - *Physician's Order Sheet* – all of these forms will normally remain in the record. Special cases, involving long-term patients and exceptionally high order volume (in excess of ¾ of an inch in thickness) will have at least 30 days of the most recent order sheets.

2. DC4-642F - *Progress Notes* – Most recent or no less than 30 days of care will remain in the chart. All other notes will be removed.

3. DC4-673B Inpatient Mental Health Daily Nursing Evaluations – Most recent or no less than 30 days (all shifts) of care will remain in the chart. All other notes will be removed.

4. Miscellaneous Section

   a. DC4-650 - *Observation Checklist* – Maintain the most recent in chart
   b. DC4-701C - *Emergency Room Record* – Maintain the most recent in chart
   c. DC4-711A - *Refusal of Healthcare Services* – Maintain the most recent in chart
   d. DC4-649 and/or DC4-545 series consent forms - Maintain the most recent in chart
   e. DC4-648 - *Drug Exception Request* – ALL WILL REMAIN in the chart
   f. Risk Reviews – Maintain the two most recent in the chart
   g. DC4-643A - *Individualized Service Plan* – Maintain the last 6 months
   h. DC4-643B - *Individualized Service Plan Review* – Maintain the last 6 months
   i. DC4-643C - *Biopsychosocial Assessment* – Maintain the last 6 months
   j. Attendance sheets – Maintain the most current
   k. DC4-701A - *MAR* - Maintain one month in chart

VI. OUTPATIENT MEDICAL AND MENTAL HEALTH RECORD (Green Jacket, DC4-745)

Order of Forms:

LEFT SIDE (file this section in the exact order as listed below)

DC4-730 *Problem List*
DH-1896 *Do Not Resuscitate Order* – Department of Health form available via Intranet
DC4-665 *Living Will*
DC4-666 *Designation of Health Care Surrogate*
DC4-688 *Mental Health Advanced Directive Declaration*
DC4-650B *Risk Assessment for the Use of Chemical Restraint Agents and Electronic Immobilization Devices*
DC4-710 *Communicable Diseases Record* (pink card)
DC4-710A *Immunization Record* (purple card)
DC4-783 *Consent for HIV Testing*

DC4-682 *HIV/AIDS Health Information Summary*
DC4-792C *Post Exposure Prophylaxis HIV Counseling*

BROWN DIVIDER (Chronic Illness Clinic Flow Sheets - file alphabetically by clinic name, with each clinic grouped together. Discontinued clinic flow sheets are moved to the bottom of this section.)
DC4-770s Flow sheets
DC4-758 *Tuberculosis/INH Health Information Summary*
DC4-520C *TB Symptoms Questionnaire for Inmates*
DC4-719 *Tuberculosis/INH Treatment for Latent TB Infection (LTBI) Nursing Evaluation*
DC4-719B *Inmate KOP INH Medication Record*

RED DIVIDER/TAB
DOH 340B Program Documentation

GRAY DIVIDER (Profile - file this section chronologically)
DC4-706 *Health Services Profile*
Inmate Photo

MEDIUM GREEN DIVIDER (Physical & RMC Discharges – file in chart order with each form grouping filed chronologically)
DC4-707 *Health Appraisal*
DC4-541 *Periodic Screening Encounter*
DC4-686 *Gynecological Examination*
DC5-211 *Inmate Fitness Program Provider Clearance Authorization*
DC4-676 *Community Facility Medical Information*

LIGHT AMBER DIVIDER (Misc Forms – file in chronological order)
Admission and discharge summaries from outside hospital(s)

PINK DIVIDER (Consents/Refusals - file chronologically by date not form order~~)~~
DC4-534 *Health Care Information Request Record*
DC4-711 *Authorization for Health Care Services/ Statement of Consent*
DC4-711A *Refusal of Health Care Services*
DC4-711B *Consent and Authorization for Use and Disclosure, Inspection and Release of Confidential Information*
DC4-744 *Release of Information Notice*
DC4-711C *Authorization for Health Evaluation and Treatment*
DC4-536 *Protected Health Information - Restriction Information*
DC4-542A *Inmate Payment Agreement for Copy of Protected Health Information*
DC4-542B *Notice of Closure for Inmate Request for Protected Health Information for Nonpayment of Copy Costs*
DC4-545A-U *Informed Consent for Psychotropic Medication*
DC4-660 *Consent to Sex Offender Treatment*
DC4-663 *Consent to Mental Health Evaluation or Treatment*
DC4-695 *Reversal of Co-payment*

DC4-699 *Uniform Donor Form*
DC4-710B *Informed Consent for Vaccine*
DC4-711H *Refusal for HIV Testing Affidavit*
DC4-711J *Informed Consent For Palliative Care – CCU (Compassionate Care Unit) Program*
DC4-783A *Informed Consent for Tamoxifen*

DARK GREEN DIVIDER (Misc Corres/Outside Info-Corres - file in chart order with each form grouping filed chronologically):
DC6-236 *Inmate Request*
DC4-774 *Acknowledgment Receipt of Special Shoes*
DC4-691 *Impaired Inmate Management and Service Work Sheet*
DC4-773 *Inmate Health Education*
DC4-750 *Community Facility Health Appraisal*
DC4-526 *Inmate Assistance Skills Checklist*
Pre-printed labels if used

RIGHT SIDE (file chronologically by date only)
Death Certificate
Autopsy Report
DC4-701 *Chronological Record of Health Care*
DC4-549 *Pre Release Health Care Summary*
DC4-715A *Surgery Record*
DC4-679 *Med Code 99 Emergency Flow Sheet*
DC4-683s *Nursing Protocols*
DC4-708 *Diagram of Injury*
DC4-760A *Health Information Transfer/Arrival Summary*
DC4-769 *Pre-Special Housing Health Evaluation*
DC4-871 *County Jail to DC Health Information Transfer Summary*
DC4-672 *Checklist for Management of Possible Foodborne Outbreak*
DC4-672A *Chicken Pox Checklist*
DC4-672B *Shingles Checklist*

LIGHT BLUE DIVIDER (Chronic Illness Clinic)
DC4-701F *Chronic Illness Clinic*
DC4-714B *Physician's Order Sheet*

LIGHT YELLOW DIVIDER (Orders/Rx/DERs -file chronologically by date only)
DC4-714B Physician's Order Sheet
DC4-648 Drug Exception Request

ORANGE DIVIDER (ER Forms file chronologically by date only)
DC4-760B Health Information Summary for Emergency Transfer to Outside Hospital
DC4-701C Emergency Room Record

LIGHT GREEN DIVIDER (file in form order with each form grouping

filed chronologically)
DC4-701A Medication and Treatment Record (MAR)
Physician Orders:
DC4-704B Dietary Prescription Display Sheet
DC4-728 Diet Prescription/Order
DC4-784 Optometric Prescription Display Sheet and Receipt of Eyeglasses
DC4-701D Health Slip/Pass

YELLOW DIVIDER (Consultations file chronologically only)
DC4-702 Consultation Request/Consultant's Report

RED DIVIDER (Lab, X-Ray, EKG file in form order as listed with each form grouping filed chronologically):
Lab, X-Ray, EKG reports
DC4-711G Periodic Screening Laboratory Report
DC4-705D Radiology Request Form

MEDIUM BLUE DIVIDER (Inpatient Record file chronologically by date):
(Medical and mental health discharges, including IMR)
DC4-713B Discharge Summary
DC4-657 Discharge Summary for Inpatient Mental Health Care

PURPLE DIVIDER (Mental Health – file in form order as listed with each form grouping filed chronologically):
DC4-643A Individualized Service Plan (Parts I, II, III)
DC4-643B Individualized Service Plan Review

GOLD SUBDIVIDER (Mental health progress notes file chronologically only)
DC4-642 Chronological Record of Outpatient Mental Health
DC4-642A Outpatient Psychiatric Follow-Up
DC4-642B Mental Health Screening Evaluation
DC4-642D Outpatient Mental Health Case Management Summary
DC4-642G Mental Health Emergency Evaluation

BLUE SUBDIVIDER (Mental Health Evaluation Reports file chronologically only)
DC4-647 Sex Offender Screening and Selection
DC4-661 Summary of Outpatient Mental Health Care
DC4-657A Transfer Summary for Inpatient Mental Health Care
DC4-729 Behavioral Risk Assessment
DC4-653 Abnormal Involuntary Movement Scale (AIMS)
DC4-643C Bio-Psychosocial Assessment
DC4-655 Psychiatric Evaluation

CHERRY SUBDIVIDER (Initial Psychological Screening Reports file chronologically only)
DC4-644 Intake Psychological Screening Report
DC4-646 Initial Suicide Profile→ not on Intranet; **CARP** generated form

DC4-659 Adaptive Behavior Checklist
DC4-664 Mental Health Attendance Record

GREEN SUBDIVIDER (Other Mental Health-Related Correspondence. file form order as listed with each form grouping filed chronologically)
DC4-528 Mental Status of Confinement Inmates
DC4-529 Staff Request/Referral
DC4-645 Intake Mental Health Screening Summary for Classification→ not on Intranet; **CARP** generated form
DC6-128 Close Management Referral Assessment
DC4-652 Review of Group Therapy Referral
Miscellaneous correspondence
DC6-236 Inmate Request (those addressed to Mental Health)

VII. DENTAL RECORDS (Light Blue Jacket, DC4-745A)

Dental records are maintained by dental staff and stored in the dental clinic as directed by the dental health service bulletins.

VIII. PSYCHOLOGICAL TESTING RAW DATA (Orange Jacket, DC4-761)

Raw test data and test protocols shall be filed only in *"Psychological Record Jacket,"* DC4-761 which shall be stored in a secure/locked cabinet in the mental health office area, during the prison commitment. The DC4-761 will be sealed and transported with the medical record wherever an inmate is transferred. Upon receipt at the gaining institution, the DC4-761 will be separated from the medical record and forwarded to the mental health office for secure storage. DC4-761, together with its content, shall be archived with the health record after release. Raw test data and test protocols (record forms/sheets) shall not be filed in the medical record.

IX. INFIRMARY AND INPATIENT MENTAL HEALTH RECORDS (Blue Jacket, DC4-746)

A. All inmates placed in the Infirmary are Admitted patients; i.e., "23 Hour Observation" status is not recognized by or used by the Department of Corrections. See HSB 15.03.26 *Infirmary Services* for additional information.

B. Infirmary records shall be maintained separately from the Outpatient Health Record (Green Jacket, DC4-745).

C. An infirmary record shall be initiated on each inmate admitted to the infirmary, regardless of the type or reason for the admission. All mental health infirmary stays require admission. The HIS shall ensure all infirmary records are in proper order and thinned appropriately. All volumes of the health record shall be available to the attending provider during the infirmary admission.

D. The infirmary forms shall be placed in the blue jacket (DC4-746) and assembled in the following sequence:

DC4-713A	Cover Sheet
DC4-713B	*Discharge Summary* (Also place a copy in the Infirmary section of the Outpatient Health Record) Include signature, stamp, date and time discharge summary was written
DC4-713C	*Inpatient History-Physical Short-Term (24-48 Hours)* (If readmission is within one month/30 days for same condition use pervious DC4-713C)
DC4-714A	*Infirmary Progress Record* (Interdisciplinary charting). In chronological order. Start with admission note and end with discharge note.
DC4-714B	*Physician's Order Sheet*. (Including admission and discharge orders.)
DC4-714D	*Infirmary Admission Orders Sheet*
DC4-679	*Med Code 99 Emergency Flow Sheet*
DC4-684	*Infirmary/Hospital Patient Daily Nursing Evaluation* OR DC4-673B *Inpatient Mental Health Daily Nursing Evaluation*. In chronological order start with admission note, shall include one entry each shift reflecting an assessment.
DC4-732	*Infirmary/Hospital Admission Nursing Evaluation*
DC4-732A	*Infirmary Admission – Test Preparation or Specimen Collection*
DC4-673A	*Inpatient Unit-To-Unit Mental Health Transfer Nursing Evaluation*
DC4-716A	*Graphic Chart*
DC4-716B	*Neurological Flow Sheet*
DC4-701K	*24-Hour Patient Positioning Activity*
DC4- 803	*Pressure Ulcer Healing Chart*
DC4-805	*Wound Treatment Record*
DC4-808	*24-Hour Ventilator Flow Sheet*
DC4-701A	*Medication and Treatment Record* (MARs).
DC4-650	*Observation Checklist*
DC4-702	*Consultation Request/Consultation Report* (Original to be placed in green Outpatient Health Record after discharge with copy in infirmary chart)

Other related applicable forms/correspondence specially relating to the individual infirmary admission.

E. The CSU/TCU/CMHI records shall be assembled with the following forms included and placed in the sequence below in the Infirmary and Inpatient Mental Health Record:

DC4-713A	Cover Sheet for Inpatient Record
EF4-656	*Referral for Inpatient Mental Health Care* ("DCE Electronic Form" on the Intranet)
DC4-657	*Discharge Summary for Inpatient Mental Health Care* (copy goes to the infirmary section of the current volume to include signature, stamp, date and time the summary is written)
DC4-713C	*Inpatient History/Physical Short Term (24-48 Hours)* (the previous DC4-713C may be used if inmate is readmitted within one month [30 days] after discharge for the same condition. Mental Health related copies of evaluations, screening summaries, profiles, histories, appraisal and/or assessments justifying this admission).

DC4-642F	*Chronological Record of Inpatient Mental Health Care* (interdisciplinary charting) shall include, in chronological order, the total clinical course of the infirmary stay as documented by the physician/psychiatrist, clinical associate, psychologist, dentist, nurse/CMT-C, therapist/psychological specialist and/or other health care providers.
DC4-673	*Inpatient Mental Health Admission Nursing Evaluation*
DC4-679	*Med Code 99 Emergency Flow Sheet*
DC4-673B	*Inpatient Mental Health Daily Nursing Evaluation*
DC4-673A	*Inpatient Unit-To-Unit Mental Health Transfer Nursing Evaluation*
DC4-714B	*Physician's Order Sheet*
DC4-650	*Observation Checklist*
DC4-716A	*Graphic Chart*
DC4-716A	*Graphic Chart*
DC4-716B	*Neurological Flow Sheet*
DC4-701K	*24-Hour Patient Positioning Activity*
DC4- 803	*Pressure Ulcer Healing Chart*
DC4-805	*Wound Treatment Record*
DC4-701A	*Medication and Treatment Record* (MAR)
DC4-704	*Laboratory Reports Display Sheet*
DC4-703	*Electrocardiogram Display Sheet* (or electronic EKG phonogram reports, as applicable)
DC4-643A	*Individualized Service Plan* (Parts I, II, III)
DC4-643C	*Biopsychosocial Assessment*
DC4-653	*Abnormal Involuntary Movement Scale (AIMS)*
DC4-626-639	CMHI Commitment Papers

Other applicable TCU/CSU forms/correspondence relating to this inpatient/infirmary admission may include, but are not limited to, CIC/ER information, consultations, inmate requests, etc.

X. MEDICAL RECORDS IN COMMUNITY CORRECTIONAL FACILITIES

A. The health record (including medical, dental and mental health records) of all inmates in community facilities will be located at the institution providing health services to the community facility.

B. DC4-549 *Prerelease Health Care Summary* will be completed by the sending institution. A copy of the-DC4-549 will be sealed in an envelope and taped to the outside of the sealed medical record. The sealed envelope will be given to the community correctional facility to be used in the event of the inmate needing emergency medical treatment or outside medical care.

XI. AFTER-HOURS ACCESS TO MEDICAL RECORDS

When health records need to be accessed for after-hour transfers of an inmate to another DC facility and health care staff are not at the facility, the following procedure will be followed:

A. The medical record must be transported with the inmate.

B. The officer in charge and one other security officer enter medical records office together.

C. There is to be a clearly marked log located in medical records office. It must be completed to reflect the signatures of the officers removing the record any time an inmate is transported.

D. The medical record is never left with the inmate at the local hospital and/or any non-DC facility.

XII. POST-RELEASE (EOS) AND DECEASE INMATES - HEALTH RECORD RETENTION AND DESTRUCTION SCHEDULE

A. Inmate health record retention and destruction timelines are based on established guidelines of the Florida Department of State, Division of Library and Information Services Records Management Program.

B. The handling of health record of inmates released from custody and/or inmates placed on parole will be as follows:

1. All comprehensive health records shall be retained in the original (hard copy) version for a period of seven (7) consecutive inactive years following release of any inmate from the Department of Corrections custody.

2. Records of inmates presently on extended parole will be maintained until release from such Department of Corrections responsibility. After seven (7) consecutive years of inactivity, the Department shall authorize destruction/recycling procedures in accordance with law.

3. Timely notification of institutional custody release shall be initiated by classification staff via the Health Information Specialist (HIS), who shall in turn ensure compliance with HSB 15.03.04 *Periodic Screenings*.

4. Upon receipt of notification of an inmate's release from custody, the HIS shall ensure that the health record is reviewed and completed (as applicable) within 48-72 hours following notification. Completion shall include the following:

a. All laboratory test results and other loose report filing shall be complete (initialed/filed).
b. A release record review/health assessment shall be documented on DC4-701 *Chronological Record of Health Care.*

c. A color coded year band shall be affixed on the health record which corresponds to the year that the inmate is released from the care and

custody of the Department of Corrections. The color coded year band shall be placed on the right outer corner of the back panel of the health record, directly above the inmate's number.

d. Remove all DC4-743-743A dividers and subdividers (medical health record and mental health record subdividers) and forward such to the nearest reception center for reuse.

e. Any colored pages can be used for dividers and placed between record sections replacing the dividers and subdividers. This will assist in the scanning process for records storage.

f. All records shall be sealed in a clear plastic bag and labeled Sensitive Medical Data To Be Opened By Medical Personnel Only before being forwarded either to Classification staff or to the Reception and Medical Center (RMC) within five (5) working days of notification.

5. Health records will be securely stored at RMC record archives. All health records received at the record archives will be checked to ensure that the color coded year band is properly attached before filing.

6. Using the color coded year band as a guide, health records which meet the seven (7) year retention schedule will be routinely identified by DC employees and prepared for destruction.

7. Health records will be stored by Reception and Medical Center medical records archive staff.

C. The handling of a deceased inmate health record(s) will be as follows:

Once a completion closure letter has been received from the Mortality Review Coordinator, the health record of the deceased inmate will be sent to RMC record archives.

Assistant Secretary of Health Services Date

This Health services bulletins Supersedes: *Health Records Manual* dated 12/92
HCS 25.12.01 dated 10/1/89
HCS 25.12.02 dated 10/1/89
HCS 25.12.03 dated 10/1/89
HCS 25.12.04 dated 10/1/89
HSB 15.12.02 dated 10/8/92
HSB 15.12.03 dated 3/13/95, 9/29/98, 4/9/03 and 04/02/13.