I. PURPOSE:

This health services bulletin (HSB) establishes health record standards for the Florida Department of Corrections (FDC). 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.

These standards and responsibilities apply to both Department staff and Comprehensive Health Care Contractor (CHCC) staff.

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

II. DEFINITIONS:

A. ***Active Health Record:*** A record 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 as well as thinned volumes or CD disks loaded with imaged copies of medical records from any previous incarcerations within the FDC.
B. ***Current Volume:*** The active health record that is presently being used for documentation.
C. ***Designated Record Set:*** 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 (RMCH) inpatient hospital files that are maintained by the Department. An inactive health record is one maintained by the Department's Statewide Records Retention Center (SRRC), which are record archives once an inmate's custody has ended (end of sentence [EOS]).
Contracted staff refers to staff that are hired by an organization contracted to provide health care services in Florida Department of Corrections' institutions.
D. ***SRRC:*** Statewide Records Retention Center located in Raiford maintains all inactive health records.

III. RESPONSIBILITIES:

A. Chief Health Officer/Institutional Medical Director—The primary responsibility for an adequate health record rests with the institutional Chief Health Officer/Institutional Medical Director.

B. 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. 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.

C. 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 FDC 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 the standards listed below in Section F.

D. Health Services Administrator (HSA)—The 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 F of this health services bulletin. The HSA is also responsible for ensuring that medical staff receive relevant and required training to ensure continuous proficiency and refresh job skills pertaining to the comprehensive health record, which include the review of all Federal Laws and Regulations, Florida Statutes, Administrative Rules, Procedures, and Health Services Bulletins.

E. 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 Director shall assign this responsibility to a qualified employee in coordination with the Chief Health Officer/Institutional Medical Director.)

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.

F. 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. Records shall be readily available to authorized users according to the HIPAA Privacy Rule, 45 CFR Subparts 160, 162 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) and 205.020 (Records Retention and Disposition).

Standard 3- The health record maintenance shall be under the supervision of a qualified health record practitioner.

Standard 4- The medical, dental and mental health records areas will be audited on a quarterly basis for misfiled/missing records or more frequently as determined by the HSA (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).

Standard 9- All records located in medical records area are to be filed alphanumerically.

Standard 10- 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 11- No food or drink is permitted in medical records documentation areas.

IV. PREPARING AND MAINTAINING HEALTH RECORD

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 depends 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 tags 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 the institution's 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. When using OBIS labels, the institution identification will be via staff providers name stamp.

3. 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. The health record (including medical, dental, and mental health records) of all inmates in work camps will be located at the institution providing health services to the work camp.

2. 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).

3. 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. Thinning 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. Additional volumes shall be identified by Roman Numerals (e.g., I, II, III etc.) with the current volume being the highest number.

   i. Volume numbers will be written directly under "HEALTH RECORD" below the FDC emblem.

Example: HEALTH RECORD
Volume #I

ii. The thinned volumes will have an additional identifier "Thinned" written under the volume number.

Example: HEALTH RECORD
Volume #II
Thinned

iii. 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.

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

4. The current record shall be placed in a new applicable jacket folder, complete with the appropriate dividers/sub-dividers (Inpatient or Outpatient).

5. On the left-hand inside of the thinned volume, on a blank sheet of paper, the HIS will write (a rubber stamp or typed statement is acceptable):

"See Vol. #II (#III, #IV, etc.) for current health status. This volume contains record entries from MM/YEAR to MM/YEAR."

6. On the right side of the current volume on DC4-701 as an incidental entry, the HIS will write:

"Record format and contents reviewed and thinned"

The entry will be dated, timed, signed and stamped by the HIS thinning the record.

V. 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)

Form #:	*Title:*	***Remain after thinning:***
DC4-730	*Problem List*	*ALL STAY*
DH-1896	*Do Not Resuscitate Order* – Department of Health form available via Intranet	*MOST CURRENT*
DC4-665	*Living Will*	*MOST CURRENT*
DC4-666	*Designation of Health Care Surrogate*	*MOST CURRENT*

DC4-688	*Mental Health Advanced Directive Declaration* **This form is no longer in use but may still be present in the medical records.*	*MOST CURRENT*
DC4-650B	*Risk Assessment for the Use of Chemical Restraint Agents and Electronic Immobilization Devices*	*3 MOS OR MOST CURRENT*
DC4-770AA-KK *CIC*	*Baseline History and Procedures*	*ALL STAY*
DC4-710	*Communicable Diseases Record* (pink card)	*ALL STAY*
DC4-710A	*Immunization Record* (yellow card)	*ALL STAY*
DC4-783B	*Acknowledge of Receipt of Orientation from Peer Educator*	*ALL STAY*
DC4-792C	*Post Exposure Prophylaxis HIV Counseling*	*ALL STAY*
DC4-812	*Sexually Transmitted Infection Counseling for Pregnant Inmates*	*1 YEAR*

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.)

Form #:	Title:	**Remain after thinning:**
DC4-770A-K	*Flow sheets*	*ALL STAY*
DC4-758	*Tuberculosis/INH Health Information Summary*	*ALL STAY*
DC4-520C	*Tuberculosis Symptoms Questionnaire for Inmates*	*MOST CURRENT*
DC4-719	*Tuberculosis/INH Treatment for Latent TB Infection (LTBI) Nursing Evaluation*	*ALL STAY*
DC4-719B	*Inmate KOP INH Medication Record*	*ALL STAY*

RED DIVIDER (File as listed below with each form grouping filed chronologically)

Form #:	Title:	**Remain after thinning:**
DOH 340B	*Program Documentation*	*LAST FOUR*
DC4-710D	*STD Screening*	*ALL STAY*

GRAY DIVIDER (Profile - file this section chronologically)

Form #:	Title:	**Remain after thinning:**
DC4-706	*Health Services Profile*	*MOST CURRENT*
	Inmate Photo	*ALL STAY*

MEDIUM GREEN DIVIDER

(Physical & RMC Discharges – file as listed below with each form grouping filed chronologically)

Form #:	Title:	**Remain after thinning:**
DC4-707	*Health Appraisal*	*RECEPTION & MOST CURRENT*
DC4-541	*Periodic Screening Encounter*	*MOST CURRENT*
DC4-686	*Gynecological Examination*	*RECEPTION & MOST CURRENT*
DC5-211	*Inmate Fitness Program Provider Clearance Authorization*	*MOST CURRENT*
DC4-676	*Community Facility Medical Information*	*ALL STAY*

LIGHT AMBER DIVIDER

(Misc Forms – file in chronological order)

Form #:	Title:	**Remain after thinning:**
	Admission and discharge summaries from outside hospital(s)	*3 MOS OR MOST CURRENT*

PINK DIVIDER

(Consents/Refusals - file chronologically by date not form order)

Form #:	Title:	**Remain after thinning:**
DC4-534	*Health Care Information Request Record*	*ALL STAY*
DC4-711	*Authorization for Health Care Services/ Statement of Consent*	*ALL CURRENT*
DC4-711A	*Refusal of Health Care Services*	*ALL*
DC4-711B	*Consent and Authorization for Use and Disclosure, Inspection and Release of Confidential Information*	*ALL CURRENT*
DC4-744	*Release of Information Notice*	*3 MONTHS*
DC4-765H	*Inspector General Medical Record Review Log*	
DC4-711C	*Authorization for Health Evaluation and Treatment*	*ALL CURRENT*
DC4-536	*Protected Health Information –Restriction Information*	*ALL STAY*
DC4-542A	*Inmate Payment Agreement for Copy of Protected Health Information*	*3 MONTHS*
DC4-542C	*Protected Health Information Copying Services Agreement for Inmate Account Withdrawal or Lien*	*3 MONTHS*
DC4-545A-Z; AA-BB	*Informed Consent for Psychotropic Medication*	*MOST CURRENT*
DC4-660	*Consent to Sex Offender Treatment*	*MOST CURRENT*

DC4-663	*Consent to Mental Health Evaluation or Treatment*	*MOST CURRENT*
DC4-695	*Reversal of Co-payment*	*3 MONTHS*
DC4-699	*Uniform Donor Form*	*ALL STAY*
DC4-710B	*Informed Consent for Vaccine*	*MOST CURRENT*
DC4-711J	*Informed Consent for Palliative Care – CCU (Compassionate Care Unit) Program*	*MOST CURRENT*
DC4-711L	*Transgender Hormone Therapy-Estrogen and Antiandrogens Informed Consent*	*ALL STAY*
DC4-711M	*Transgender Hormone Therapy-Testosterone Informed Consent*	*ALL STAY*
DC4-711N	*Impaired Inmate Request and Agreement to Display Confidential Information about Impairments and/or Disabilities*	*ALL STAY*
DC4-783A	*Informed Consent for Tamoxifen*	*MOST CURRENT*

YELLOW DIVIDER (ADA) (File as listed below with each grouping filed chronologically)

Form #:	Title:	**Remain after thinning:**
DC4-691	*Disabled Inmate Management and Service Plan*	*ALL STAY*
DC4-691B	*Documentation of Personal Wheelchair*	*ALL STAY*
DC4-702A	*Vision Assessment*	*2 MOST RECENT*
15.03.25.01 App A	*Auditory Screening*	*2 MOST RECENT*
15.03.25.02 App A	*Mobility Screening*	*2 MOST RECENT*
15.03.25.02 App B	*Mobility Impaired Inmate Monthly Skin Assessment Checklist*	*4 MOST RECENT*
15.03.25.03 App A	*Vision Screening*	*2 MOST RECENT*

DARK GREEN DIVIDER

(Misc. Corresp./Outside Info-Corresp. - file in chart order with each form grouping filed chronologically)

Form #:	Title:	**Remain after thinning:**
DC6-236	*Inmate Request*	*3 MONTHS*
DC4-774	*Acknowledgment Receipt of Special Shoes*	*MOST CURRENT*
DC4-773	*Inmate Health Education*	*ALL STAY*
DC4-779A	*Do You Know…Tobacco Cessation Assistance*	*CURRENT*
DC4-750	*Community Facility Health Appraisal*	*CURRENT*
DC4-526C	*Inmate Assistant Annual Requirements Checklist*	*MOST CURRENT*

DC4-526D	*Inmate Assistant Request for Withdrawal from the Program*	*MOST CURRENT*

RIGHT SIDE (file chronologically by date only)

Form #:	Title:	**Remain after thinning:**
	Death Certificate	
	Autopsy Report	
DC4-524	*Release of Body*	
DC4-502	*Institutional Death Summary*	
DC4-701	*Chronological Record of Health Care*	*3 MONTHS*
DC4-684D	*Hunger Strike Daily Assessment*	*6 MONTHS*
DC4-549	*Pre-Release Health Care Summary*	*MOST CURRENT*
DC4-549A	*Pre-Release Health Care Supplemental*	*MOST CURRENT*
DC4-715A	*Surgery Record*	*3 MONTHS*
DC4-679	*Med Code 99 Emergency Flowsheet*	*3 MONTHS*
DC4-683s	*Nursing Protocols*	*3 MONTHS*
DC4-698A	*Inmate Sick Call Request*	*3 MONTHS*
DC4-803	*Pressure Ulcer Healing Chart*	*3 MONTHS*
DC4-811	*Outpatient Wound Evaluation and Treatment-Wound Treatment Record*	*3 MONTHS*
DC4-732A	*Infirmary Outpatient Admission – Test Preparation or Specimen Collection*	*3 MONTHS*
DC4-732B	*Infirmary Outpatient Admission –23 Hour Observation Nurses Note*	*3 MONTHS*
DC4-708	*Diagram of Injury*	*3 MONTHS*
DC4-760A	*Health Information Transfer/Arrival Summary*	*MOST CURRENT*
DC4-769	*Pre-Special Housing Health Evaluation*	*3 MONTHS*
DC4-871	*County Jail to DC Health Information Transfer Summary*	*MOST CURRENT*
	County Jail Specific Transfer Summary	*MOST CURRENT*
DC4-672	*Checklist for Management of Possible Foodborne Outbreak*	*3 MONTHS*
DC4-672A	*Chicken Pox Checklist*	*3 MONTHS*
DC4-672B	*Shingles Checklist*	*3 MONTHS*
	Reception Assessment ➡ *not on Intranet, OBIS reception generated form*	

LIGHT BLUE DIVIDER (Chronic Illness Clinic) (File chronologically by date)

Form #:	Title:	**Remain after thinning:**
DC4-701F	*Chronic Illness Clinic*	*LAST FOUR*

LIGHT YELLOW DIVIDER (Orders/Rx/DERs -file chronologically by date only)

Form #:	Title:	**Remain after thinning:**

DC4-714B	*Clinician's Order Sheet*	*ALL STAY*
DC4-714C	*DEA Controlled Substances Physician's Order Sheet*	*ALL STAY*
DC4-648	*Drug Exception Request*	*1 YEAR*
DC4-714E	*Standing Orders for OTC Medications*	*1 YEAR*

ORANGE DIVIDER (ER Forms file chronologically by date only)

Form #:	Title:	**Remain after thinning:**
DC4-760B	*Health Information Summary for Emergency Transfer to Outside Hospital*	*3 MONTHS*
DC4-701C	*Emergency Room Record*	*3 MONTHS*

LIGHT GREEN DIVIDER (file in form order with each form grouping filed chronologically)

Form #:	Title:	**Remain after thinning:**
DC4-701A	*Medication and Treatment Record (MAR)*	*3 MONTHS*
DC4-701I	*Subcutaneous Injection Site Diagram*	*3 MONTHS*
	Physician Orders:	
DC4-728B	*Therapeutic Diet Request*	*CURRENT*
DC4-728	*Diet Prescription/Order*	*CURRENT*
DC4-704B	*Dietary Prescription Display Sheet*	*CURRENT*
DC4-784	*Optometric Prescription Display Sheet and Receipt of Eyeglasses*	*CURRENT*
DC4-701D	*Health Slip/Pass*	*CURRENT*
DC4-704C	*Health Slip/Pass Display Sheet*	*2 YEARS*

YELLOW DIVIDER

(Consultations file chronologically only)

DC4-702	*Consultation Request/Consultant's Report*	*3 MONTHS or MOST CURRENT*

RED DIVIDER

(Lab, X-Ray, EKG file in form order as listed with each form grouping filed chronologically)

Form #:	Title:	**Remain after thinning:**
	Lab	
DC4-711G	*Periodic Screening Laboratory Report*	*THIN TO 3 MOS OR MOST CURRENT + EXCEPTIONS*
DC4-704	*Laboratory Reports Display Sheet*	
DC4-704A	*Intake Physical Laboratory Reports*	
DC4-705D	*Radiology Request Form (with X-Ray report and EKG reports)*	
DC4-703	*Electrocardiogram Display Sheet*	

MEDIUM BLUE DIVIDER

(Inpatient Record file chronologically by date)

(Medical and mental health discharges, including IMR)

Form #:	Title:	**Remain after thinning:**
DC4-713B	*Discharge Summary*	*PAST 2 YRS. OR 3 MOST CURRENT FROM EACH AREA*
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)

Form #:	Title:	**Remain after thinning:**
DC4-643A	*Individualized Service Plan (Parts I, II, III)*	*THIN TO MOST CURRENT*

GOLD DIVIDER

(Mental health progress notes file chronologically only)

Form #:	Title:	**Remain after thinning:**
DC4-642	*Chronological Record of Outpatient Mental Health*	*6 MONTHS OR MOST CURRENT*
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 DIVIDER

(Mental Health Evaluation Reports file chronologically only)

Form #:	Title:	**Remain after thinning:**
DC4-647	*Sex Offender Screening and Selection*	*THIN TO 3 MOS OR MOST CURRENT*
DC4-661	*Summary of Outpatient Mental Health Care*	
DC4-657A	*Transfer Summary of Inpatient Mental Health Care*	
DC4-729	*Behavioral Risk Assessment*	
DC4-653	*Abnormal Involuntary Movement Scale (AIMS)*	*THIN TO 3 MOS OR MOST CURRENT*
DC4-643C	*Bio-Psychosocial Assessment*	
DC4-655	*Psychiatric Evaluation*	

CHERRY DIVIDER

(Initial psychological screening reports file chronologically only)

Form #:	Title:	**Remain after thinning:**
DC4-644	*Intake Psychological Screening Report*	*ALL STAY*
DC4-646	*Initial Suicide Profile-not on Intranet; OBIS reception generated form*	
DC4-659	*Adaptive Behavior Checklist*	
DC4-664	*Mental Health Structured Out-Of-Cell Treatment and Services Attendance Record*	

GREEN DIVIDER

(Other Mental Health-Related Correspondence. file form order as listed with each form group in filed chronologically)

Form #:	Title:	**Remain after thinning:**
DC4-528	*Mental Status of Confinement Inmates*	*3 MONTHS*
DC4-529	*Staff Request/Referral*	*3 MONTHS*
DC4-645	*Intake Mental Health Screening Summary for Classification → not on Intranet;* ***OBIS*** *generated form*	*STAYS*
DC6-128	*Close Management Referral Assessment*	*CURRENT*
DC4-652	*Review of Group Therapy Referral*	*CURRENT*
Miscellaneous correspondence		*3 MONTHS*
DC6-236	*Inmate Request(those addressed to Mental Health)*	*3 MONTHS*
EF6-013		
EF6-014		
EF4-656	*Referral for Inpatient Mental Health Care*	

VI. 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.

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

Raw test data and test protocols shall be filed only in DC4-761, *Psychological Record Jacket* 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.

VIII. INFIRMARY (Inpatients, Outpatients, SHOS Patients) (See also HSB 15.03.26 and the FDC Nursing Manual)

A. There are two (2) categories of Infirmary Admissions:

1. **INPATIENTS** – BLUE JACKET Medical Record (DC4-746)

a. **Acute Illness Patients** (patient who is expected to be discharged within ~2-3 weeks; e.g., unstable diabetic who develops pneumonia during admission)

b. **Chronic Illness Patients** (patient requires several weeks of care but is expected to recover and return to open pop eventually) **/ Long Term Care Patients** (e.g., patient with dementia, patient with ALS on a respirator, etc.; a patient who's condition is expected to deteriorate)

c. **Self-Harm Observation Status (SHOS) Patients** – inmates with a Mental Health classification grade of S-1 through S-3 who require a controlled environment and close staff observation. These patients may be admitted to an Infirmary SHOS cell or to a AC or DC cell. Regardless of their location, they are considered an Infirmary Inpatient Admission.

2. **OUTPATIENTS –** GREEN JACKET Medical Record (DC4-745)

a. **23-Hour Observation Patients** – an acutely ill patient the doctor wants to be assessed and observed by nursing staff in the Infirmary for 23 hours or less. At the end of 23 hours, the doctor is to either discharge the patient back to open pop (or AC/DC), admit the patient to the Infirmary as an Acute Illness patient, or transfer the patient to an outside facility for evaluation, tests, and possible admission.

b. **Test Prep/Specimen Collection Patients** – generally speaking non-ill patient who's admitted to the Infirmary for the convenience of conducting a test prep (barium enema scheduled the next day) or specimen collection (24-Hour urine collection)

IX. MENTAL HEALTH INPATIENT UNITS (CSU, CMHTF, TCU, SHOS Patients) – BLUE JACKET Medical Record (DC4-746)

A. Patients admitted to a mental health inpatient unit (CSU, TCU, CMHTF) will have an Inpatient (blue jacket, DC4-746) medical record.

B. The inpatient mental health patient who is placed on Self-Harm Observation Status (SHOS/ MHOS) will continue to have their paperwork added to their current Inpatient blue jacket folder.

X. Order of Forms- (Infirmary/Mental Health Inpatient Unit)

*Forms only used in Mental Health Inpatient Unit Record

**Forms only used in infirmary admissions

ADMISSIONS *(combine by type then file chronologically)*

Form #:	Title:	**Remain after thinning:**
	Labels	
DC4-713A	*Cover Sheet for Inpatient Record*	

DC4-626	*Petition for Placement in a DOC MH Treatment Facility*	*ALL STAY*
DC4-627	*Notice of Petition for Placement in a DOC MH Treatment Facility*	
DC4-631	*Notice of Hearing on Petition for Placement in a DOC MH Treatment Facility*	
DC4-632	*Application for Attorney*	
DC4-633	*Order for Placement in a DOC MH Treatment Facility*	
DC4-634	*Request for Order Authorizing Continued Placement in a DOC MH Treatment Facility*	
DC4-635	*Notice to Inmate of Request for Continued Placement in a DOC MH Treatment Facility*	
DC4-636	*Waiver of Hearing for Continued Placement in a DOC MH Treatment Facility*	
DC4-639	Application for Attorney – Continued Placement	
EF4-656	*Referral for Inpatient MH Care*	
DC4-657	*Discharge Summary of Inpatient MH Care**	
DC4-730	*Problem List (copied from outpatient record)*	
DC4-706	*Health Services Profile*	
DC4-714D	*Infirmary Admission Order Sheet***	
DC4-732	*Infirmary/Hospital Admission Nursing Evaluation***	
DC4-732A	*Infirmary Outpatient Admission- Test Preparation or Specimen Collection***	
DC4-673	*Inpatient Mental Health Admission Nursing Evaluation**	
DC4-673A	*Inpatient Unit-to-Unit Mental Health Transfer Nursing Evaluation**	

NURSING ASSESSMENT *(combine in chronological order)*

Form #:	Title:	**Remain after thinning:**
DC4-673B	*Mental Health Daily Nursing Evaluation**	
DC4-684	*Infirmary/Hospital Patient Daily Nursing Evaluation*	
DC4-684D	*Hunger Strike Daily Assessment*	*THIN TO 30 DAYS*

DC4-684A	*Morse Fall Scale*	
DC4-684B	*Post Fall Protocol*	
DC4-804	*Braden Scale for Predicting Pressure Sore Risk (files as a group at the back of the tab)*	

PHYSICIAN'S ORDERS *(combine in chronological order)*

Form #:	Title:	**Remain after thinning:**
DC4-648	*Drug Exemption Request* (DER)	*ALL STAY*
DC4-714B	*Clinician's Order Sheet*	
DC4-714C	*DEA Controlled Substance Clinician's Prescription/Order Sheet*	

HISTORY AND PHYSICAL *(combine by type then file chronologically)*

Form #:	Title:	**Remain after thinning:**
DC4-713C	*Inpatient History/Physical**	*ALL STAY*
DC4-643C	*Biopsychosocial Assessment**	*2 MOST RECENT STAYS*
DC4-655	*Psychiatric Evaluation**	*STAYS*
DC4-653	*Abnormal Involuntary Movement Scale (AIMS)**	*LAST TWO*

PLAN OF TREATMENT *(combine by type then file chronologically)*

Form #:	**Title:**	**Remain after thinning:**
DC4-642B	*Mental Health Screening Evaluation**	*6 MONTHS OR MOST RECENT*
DC4-643A	*Individualized Service Plan**	*6 MONTHS OR MOST RECENT*
DC4-643D	*Self-Injury Reduction Plan**	*ALL STAY*
DC4-642Q	*Psychological Violence Risk Assessment**	*ALL STAY*
DC4-661	*Summary of Outpatient Mental Health Care**	*ALL STAY*
DC4-657A	*Transfer Summary for Inpatient Mental Health Care**	*ALL STAY*
DC4-664	*Mental Health Structured Out-Of-Cell Treatment and Services Attendance Record**	*THIN TO 3 MONTHS*
DC4-729	*Behavioral Risk Assessment* (BRA)*	*MOST RECENT*

PROGRESS NOTES

(Psychiatrist, M.D., ARNP, Psychologist, Case Manager, Therapist)

(Combine in chronological order)

Form #:	**Title:**	**Remain after thinning:**
DC4-714A	*Infirmary Progress Note***	*CSU- THIN TO 30 DAYS*

DC4-642F	*Chronological Record of Inpatient Mental Health Care**	*TCU- THIN TO 3 MONTHS*
DC4-642G	*Mental Health Emergency Evaluation*	
DC4-642H	*Inpatient Psychiatric Follow-up*	
DC4-642I	*Inpatient Unit Clinical Group Therapy Note*	
DC4-642J	*Inpatient MH Screening Evaluation*	
DC4-642K	*Inpatient MH Weekly Summary Note*	
DC4-642L	*Inpatient MH Case Management*	
DC4-642M	*MDST Meeting Docket*	
DC4-642N	*Inpatient Psychoeducational Group Incidental Note*	
DC4-642P	*Inpatient Individual Psychotherapy Note*	
DC4-642R	*Inpatient Well-Being Check Incidental Note*	
DC4-642S	*Inpatient Well-Being and Mental Status Exam*	

GRAPHIC SHEETS *(combine by type then file chronologically)*

Form #:	Title:	Remain after thinning:
DC4-716A	*Graphic Chart*	*THIN TO 30 DAYS*
DC4-537	*Daily Intake and Output*	
DC4-716B	*Neurological Flow Sheet*	
DC4-803	*Pressure Ulcer Healing Chart*	*THIN TO 30 DAYS*
DC4-701K	*24-Hour Patient Positioning Activity Schedule*	

FLOW SHEETS *(combine in chronological order)*

Form #:	Title:	Remain after thinning:
DC4-650	*Observation Checklist*	*THIN TO 30 DAYS*
DC4-650A	*Restraint Observation Checklist*	

LABORATORY REPORTS *(chronological order)*

Form #:	Title:	Remain after thinning:
	*Lab Reports***	*ALL STAY*

X-RAY & EKG

Form #:	Title:	Remain after thinning:
DC4-705D	*Radiology Request Form*	*ALL STAY*
	Radiology Reports	
	Electrocardiogram Reports	

CONSULTS

Form #:	Title:	Remain after thinning:
DC4-702	*Consultation Request/Consultation Report*	*ALL STAY*

MEDICATION AND TREATMENT

Form #:	Title:	Remain after thinning:
DC4-701A	*Medication and Treatment Record (MAR)*	*THIN TO 3 MONTHS*

CONSENTS *(combine in chronological order)*

Form #:	Title:	Remain after thinning:
DC4-649	*Consent to Inpatient Mental Health Care*	*MOST CURRENT*
DC4-663	*Consent to Mental Health Evaluation/Treatment*	
DC-711A	*Refusal of Health Care Services*	
DC4-545A-Z; AA-BB	*Informed Consent for Psychotropic Medication*	

MISCELLANEOUS *(combine by type then file chronologically)*

Form #:	Title:	Remain after thinning:
	Risk Assessment (RAT)	*MOST RECENT 2 STAYS*
DC4-529	*Staff Request/Referral*	*ALL STAY*
DC4-701C	*Emergency Room Record*	*MOST RECENT*
DC4-708	*Diagram of Injury*	*MOST RECENT*
DC4-704B	*Dietary Prescription Display Sheet*	*ALL STAY*
DC4-728B	*Therapeutic Diet Request*	*LAST TWO*
DC4-728	*Diet Prescription/Order*	*LAST TWO*

DISCHARGE PLANNING

Form #:	Title:	Remain after thinning:
DC4-713B	*Discharge Summary*****	*ALL STAY*
DC4-657	*Discharge Summary for Inpatient Mental Health Care**	*ALL STAY*

XI. MEDICAL RECORDS FOR TRANSFER TO OUTPATIENT MEDICAL AND MENTAL HEALTH RECORD (GREEN JACKET DC4-745)

A. While in the infirmary or a mental health inpatient unit (CSU, TCU, CMHTF), documentation of all health and mental health care will be filed in the patient's inpatient record.
B. An incidental note documenting the patient's admission to the infirmary or mental health inpatient unit, including the time and date of the admission, will be recorded in the patient's outpatient record.
C. Within seventy-two (72) hours after discharge, a copy of this section should be filed in the Green Jacket in accordance with Section V. of this HSB.
D. All copies should be marked "This Encounter Occurred on Inpatient Status".

XII. FORWARDING RECORD SETS OF ACTIVE INMATE

It is the responsibility of the HIS/Supervisor to send all volumes of the health record (active, inactive, mental health, dental, psychological, inpatient and outpatient) with the inmate upon transfer. Documentation of records sent will be noted on the DC4-701, *Chronological Record of Health Care*. See example below (use of stamp is recommended):

Incidental Note: Transfer In/ Transfer Out/ EOS
___Record Reviewed
Records Received/Sent
___Medical Record, ____# of Vols.
___Dental Record
___Psychological Record
Missing Volumes Requested: Y N

If discovered that any volume of a record set/loose filing of an active inmate had not been transferred with inmate, these records will be forwarded immediately to the receiving HIS/Supervisor. Records will be handled as listed below:

1. Records will be sent **via FedEx/UPS ground** to the current institution of the active inmate.
2. Mailing label should be to the attention of the "Medical Records Department", as well as, the box/package should be marked "Confidential Medical Records- To be Opened by Medical Staff Only".
3. The sending HIS will forward the tracking information (inmate name, DC# and what records) for the record(s) that are being forwarded to the receiving HIS.
4. HIS will track the movement of the package.
5. The sending HIS will contact shipping company immediately if records were not received by the receiving site as indicated.
6. **NO** active Medical Records will be transferred on bus without active inmate present.

XIII. 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.

XIV. 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.

XV. PREVIOUS INCARCERATED INACTIVE MEDICAL RECORDS

For those inmates that were previously incarcerated in a DC facility, the SRRC may send to the permanent institution, CD disk(s) with imaged copies of the inmate's previous excessive inactive medical record to be placed in the active volume of the inmate's medical record. For CDs, the HIS will make sure that:

A. All CDs are placed in a sealed 9x7 envelope.
B. Envelope should be labeled on the outside with Inmate Name, DC# and # of disks contained in envelope.
C. Label will be used as the seal on envelope.
D. Punch holes in top of envelope.
E. Place in last page of inside left hand side of record.
F. Note on outside of health record "inactive CDs" thinned volumes will have an additional identifier "Thinned" written under the volume number.

Example:
HEALTH RECORD
Volume #I
Thinned
Inactive CD 3/3

XVI. MISSING MEDICAL RECORD

It is the responsibility of the Medical Records Department to send all volumes of medical records (active, inactive, dental, psychological, inpatient, and outpatient) with the inmate. The sending HIS must notify the receiving HIS if it discovers that part of the medical records are missing; and will advise the receiving HIS immediately. The missing records will be forwarded immediately to the receiving HIS.

The HIS will cross-reference health care records received with a daily gain sheet and will verify the arrival of each comprehensive medical record. It is the responsibility of the HIS to locate and retrieve any missing or incomplete records. Document the action(s) taken to retrieve the medical records and whether the records were received or not on the DC4-701, Chronological Record of Health Care.

When it is determined that a medical record set (in part or in whole) is missing the following steps will be followed:

1. When it is determined at the receiving institution that an inmate was gained without a particular record set, the receiving institution's HIS will contact the sending institution's HIS. The sending institution will initiate an active and inactive vault audit of all record sets, conduct a search of all clinical areas and offices for the missing record, and will notify the receiving institution's HIS.

    i. When it is determined that a health record (dental/medical/mental health) is missing at any other time the HIS will initiate an active and inactive vault audit of all record sets and will search all clinical areas and offices for the missing record.

    ii. If the record set is not located as a result of engaging in the above steps, the HIS will contact the HSA or designee. The HSA or designee will contact the Statewide Records Coordinator to initiate a state-wide search for the missing record set.

    iii. If after two (2) attempts the record set is still not located, the Statewide Records Coordinator will notify the HSA or designee to initiate an incident report noting the date and time the record was discovered as missing and the steps taken to locate the record set. A copy of the incident report with the tracking numbers will be forwarded to the Statewide Records Coordinator.

    iv. If the missing record set is the active volume, a temporary record will be created as outlined in IV (b) of this bulletin and the event be documented on the "Chronological Record of Health Care," DC4-701. With a black permanent pen, the front of the medical record should also be labeled, "Temp Record".

    v. The Statewide Records Coordinator will maintain a continuous log with all reported missing records. If a record is located, thereafter, the Statewide Records Coordinator will be notified and log will be updated.

    vi. All needs or concerns regarding missing records will be directed to the Statewide Records Coordinator for resolution.

XVII. DAMAGED MEDICAL RECORD

A. When there is a need to repair/photocopy the original record(s) in order to restore and use it due to damage, the HIS who repairs/photocopies the record(s) must attest and certify that the copy is an accurate copy of the original by completing DC4- 535, Satisfactory Affidavit and place a copy of document in repaired/photocopied record.

B. Photocopies must meet "minimum standards" in accordance with Rules 1B-26.0021 and 1B-26.003, FAC.

C. Once the photocopy record is designated as the master copy, disposal of the paper original must comply with the retention requirements.

XVIII. 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 and Procedure 205.020, Records Retention and Disposition.

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 HIS, who shall in turn ensures 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 thirty (30) working days 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. Remove all DC4-743 dividers (medical health record and mental health record dividers) and forward such to the nearest reception center for reuse.

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

e. 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 to the SRRC. Records should be prepared to be sent on the schedule pick up, which is every thirty (30)- forty five (45) days.

5. Health records will be securely stored at SRRC 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. Health records will be stored by the SRRC 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 SRRC record archives.

Health Services Director 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