**Medical Records Information**

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**Requirements** = the minimum framework outlined in broad terminology which is legally required in veterinary records in British Columbia as per the Veterinary Code of Ethics and the Facility Standards Appendix.

**Standards** = the peer accepted expectations & specific details expected to be included in veterinary medical records in British Columbia.

**A Medical Record includes:**

Both electronic/computerized and written/paper components

Client Registration Forms and Contact Information - owners/agents name, address & phone numbers

Patient Information - name, species, breed, age, sex, coat colour, and any identifying marks (tattoo, microchip)

Emergency Contact Numbers

DATE of all entries, the WEIGHT of the patient & each entry must be INITIALED

Written Data = Presenting Complaint, History with appropriate Detail, Clinical Signs, Documented Physical Exam, An Assessment of the Animal, Recommended Tests, Advice, and Performed Diagnostic Tests including Interpretations, A Diagnosis or Tentative Diagnosis, Both Planned and Instituted Treatments, A Summary of ALL Verbal or Written Communications with Owners, & a Notation of any House-call.

Results = Study Details including Lab Work Results, Pathology Reports, X-Rays, Other Diagnostic Imaging, Special tests & Necropsy Findings.

Treatment = Drugs - Dosages or Doses for all administered (injection sites & depth) and dispensed (including Drug NAME, CONCENTRATION/STRENGTH/SIZE, MANUFACTURER NAME or BRAND NAME, DIN number, AMOUNT/QUANTITY, DURATION of usage, EXPIRY DATE, and any SAFETY WARNINGS) and any withdrawal information for food animals.

Fluids - TYPE, RATE, TOTAL VOLUME INFUSED, ANY ADDITIVES & LOCATION OF CATHETER

Supportive Care - THERMOREGULATION, ISOLATION, ALTERNATIVE THERAPIES/TREATMENTS

Anesthetics - MONITORING FORMS detailing date, time, procedure, personnel, drugs, doses, routes, administration, monitoring equipment, the patient's response every 5 minutes at min., any complications and recovery data every 15 mins right up until the pet is discharged

Surgery Protocols - Details of PREPARATION, APPROACH, TISSUE APPEARANCE, HANDLING, SAMPLING, SUTURING TYPE & METHOD, STABILITY DURING SURGERY AND POST-OP RECOVERY.

Master Problem Lists or Cumulative Patient Profiles - including Vaccination Status, Medical & Surgical History, and any Adverse Reactions Experienced

Referral Forms that have been sent to other Veterinary Facilities

Records received from Referral/Emergency/Second Opinion Veterinarians

Abbreviation Lists & Standard Protocols for your Clinic

ALL Patient FORMS including but not limited to:

Estimates, Completed/Submitted Insurance Forms, Vaccine Certificates, Microchip Forms, Discharge Information, Consent Forms, Admission Forms, Export Permits, Letters written by the DVM on behalf of the pet/pet owner, SPCA Information, Boarding Information, Dental records, Scripts & Clinic Protocols.

LOG BOOK ENTRIES

Radiology Log Book - date, owner ID, patients ID, technique information (mA, kVp, time), area of study, tissue depth, operators name and timing where applicable, plus the dose of contrast material if used.

Anesthetic Surgery Log - date, owner ID, patient ID, procedure performed, anesthetic name, dose & route of pre-medications, induction agents, maintenance gas and any other anesthetics, time elapsed and the name of the veterinarian performing the procedure, weight, pre & post-op patient condition.

Controlled Drug Log - date dispensed, hospital name, name of prescribing veterinarian, client name & address, animal name or ID, drug name, strength/concentration, quantity, DIN, the quantity remaining after dispensing, and initials. Two person Audit every 1-2 weeks.

X-Rays

Each film must be identified with facility name, name of veterinarian, patient ID, owner name, date, spatial position indicator where appropriate and time or operating parameters if barium or CT studies.

All Itemized Billing Records - the fees/charges for all visits, treatments, procedures, and all saleable items.

When you submit medical records to the CVBC, **ALL of these components** will be required.

Medical Records must be:

Legible Complete Containing Appropriate Detail

Secure Confidential Organized Logical

Accurate Initialed Timely Current

REMEMBER: 70% of all complaints stem from a breakdown in communication

If it isn't recorded/written down... then it didn't happen...