OUTPATIENT HEALTH RECORD FORMAT

The Health Record is arranged in reverse chronological order from the current date to the date of admission.

SIDE I: Administrative Section

1. Refusal of Treatment
2. Consent to Minor Surgical or Invasive Procedure
3. Consent for Disclosure of Information
4. Medical Inpatient Discharge Packet and/or a copy of the Short Stay Admission record.
5. Freeworld records
6. Organ Donor Cards

SIDE II: Mental Health Section

1. Medical Alert
2. Clinic notes
3. Abnormal Involuntary Movement Scale (AIMS)
4. Individual Treatment Plans
5. Observation Checklist for Crisis Management, Psychological Observation, Seclusion or Restraint
6. Initial Mental Health Screening Interview (CL-69, HSP-31)
7. Inpatient Discharge Summary
8. Observation Checklist for Crisis Management, Mental Health Observation, Seclusion or Restraint
9. Developmental Disabilities Program (Formerly Mentally Retarded Offender Program)
    a. Individualized habilitation form (IHP)
    b. DMR Evaluation
    c. Vocational evaluation

SIDE III: Additional Programs

Dental Divider

1. Dental Section

    a. Dental Health Records/Subsequent Exam
    b. Dental Services Rendered Continuation Sheet
    c. Periodontal Exam Chart (if applicable)
    d. Plaque Index Scoring (if applicable)
    e. Dental Health Record/Inprocessing Exam

ADS Divider:

1. Special Programs (ADS formerly known as PHOP)

    a. Podiatry Section

        1. Operative Report
        2. Surgery Report
        3. Anesthesia Record
        4. Pre-operative Checklist

    b. Assistive Disability Services

        1. ADS Discharge Summary
        2. ADS Social History
        3. ADS Individual Treatment Plan
        4. ADS Occupational Therapy Assessment
        5. ADS Physical Therapy Evaluation
        6. ADS Initial Skin Assessment
        7. ADS Individual Treatment Plan Review

2. Audiology Section

    a. Audiometer Information Printout
    b. Audiometer Test Record
    c. Extended Subject History

3. Ophthalmology Section

    a. Optometry Record
    b. Ophthalmology Record
    c. Amsler Recording Chart

4. Physical Therapy/Respiratory Therapy
    a. Physical Therapy Notes
    b. Respiratory Care Service Flowsheet
    c. Spirometrics Forms 2116 and 2207

SIDE IV:

1. Panorex and other dental x-rays

2. Previous incarceration envelope/inpatient psychiatric and medical microfilm/volume microfilm

3. OB/GYN Section (female units only): information resulting from the services provided by John Sealy OB/GYN practitioners at the Gatesville and Texas City facilities.

4. Dialysis Section: Services specifically provided by the contracted dialysis department.

SIDE V.

1. Medication Administration Record (MAR) - A copy of the most current computer generated MAR will be placed here.

Master Problem List Divider:

1. Health Summary for Classification

2. Immunization Section

    a. TB Skin Test and Vaccination Record
    b. TB History and Classification
    c. TB Patient Monitoring Record
    d. TB 400/410
    e. State Disease Reports

3. H & P Section

    a. Physical Exam
    b. PULHES
    c. Report of Physical Exam
    d. Personal History
    e. Pre-segregation Health Physical
    f. Receiving Screening

Chronic Clinic Divider

1. Individualized Treatment Plans

Health Services Referral Divider

1. Consultations from Specialty Clinics (TDCJ-HG, RMF's, etc.)

Flow Divider

1. Treatment
2. Solitary
3. Chronic Care Flow Sheets
4. Respiratory care, etc.

Lab Divider: includes all lab forms

X-ray Divider: x-ray reports

Electrocardiogram (EKG); Electroencephalogram (EEG) Divider: EKG & EEG readings

SIDE VI: Items 1-4 filed in chronological order together:

1. Clinic Notes
2. Nurses Incoming Chain Review
3. Nursing Protocols
4. Emergency Medical Services
    a. Emergency Record
    b. Emergency Nursing Care Record
    c. EMS Run Sheet
    d. EMS Ambulance Activity Report Supplement

INPATIENT HEALTH RECORD FORMAT

1. Discharge Summary (only if the patient has been discharged)
2. Master Problem List
3. Consultation Report
4. Health Services Referral
5. History and Physical
6. Short Stay History and Physical (if applicable)
7. Physician Orders
8. Integrated Progress Notes
9. Nurses Notes
10. Nursing Initial Assessment
11. Inpatient Medication Administration Record (MAR) - A copy of the most current month's computer generated MAR will be placed in front of the History and Physical in the front of the chart. All doses administered must be documented on the computer. User instructions for the MAR program can be found in the Pharmacy Policy and Procedure Manual.
12. Laboratory
13. Radiology
14. Electrocardiogram (EKG)
15. Electroencephalogram (EEG)
16. Respiratory Therapy Inpatient Flow Sheet
17. Physical Therapy
18. Pathology Reports
19. Miscellaneous:

    a. Physician Advanced Directive
    b. Consent for Surgical Procedure
    c. Refusal of Treatment
    d. Anesthesia Record
    e. Operative Report

f. Surgery Record
g. Preoperative Check List
h. Emergency Room Record
i. Request for Non-formulary Drugs