

 <p>SASKATOON DISTRICT HEALTH</p>	<p>POLICIES & PROCEDURES</p> <p>Number: 7311-75-007 Title: Documentation Standards - Health Records</p>
<p>Authorization</p> <p><input type="checkbox"/> Board of Directors <input checked="" type="checkbox"/> Senior Leadership Team <input type="checkbox"/> Vice President</p>	<p>Source: Clinical Records Committee Cross Index: Date Reaffirmed: Date Revised: Date Effective: June 2004 Scope: Former SDH</p>

1.0 Policy:

- 1.1 A health record shall be maintained for each individual who receives health-care services within the programs of Saskatoon District Health (SDH).
- 1.2 All significant clinical information is incorporated in the health record.
- 1.3 The health record is available to clinicians for continuing care.

2.0 Purpose:

- 2.1 To comply with provincial legislation.
- 2.2 To serve as a basis for planning patient care and for continuity in the evaluation of the patient's condition and treatment.
- 2.3 To furnish documentary evidence of the course of the patient/client's evaluation, treatment, and change in condition.
- 2.4 To document communication between the practitioner responsible for the patient and any other health-care professional that contributes to the patient care.
- 2.5 To assist in protecting the legal interest of the patient, the organization, and the practitioner responsible for the patient.
- 2.6 To provide data for use in continuing education and in research.

3.0 Procedure:

- 3.1 Follow the Documentation Standards - Appendix A