Patient Record Content

The Standards of Practice of the College of Physicians & Surgeons of Alberta ("the College") are the minimum standards of professional behavior and ethical conduct expected of all regulated members registered in Alberta. Standards of Practice are enforceable under the Health Professions Act and will be referenced in the management of complaints and in discipline hearings. The College of Physicians & Surgeons of Alberta also provides Advice to the Profession to support the implementation of the Standards of Practice.

(1) A regulated member who provides assessment, advice and/or treatment to a patient must:

(a) document the encounter in a patient record (paper or electronic);

(b) ensure the patient record is:

(i) an accurate and complete reflection of the patient encounter to facilitate continuity in patient care;

(ii) legible and in English;

(iii) compliant with relevant legislation and institutional expectations; and

(iv) completed as soon as reasonable to promote accuracy.

(2) A regulated member must ensure the patient record contains:

(a) clinical notes for each patient encounter including:

(i) presenting concern, relevant findings, assessment and plan, including follow-up when indicated;

(ii) prescriptions issued, including drug name, dose, quantity prescribed, directions for use and refills issued;

(iii) tests, referrals and consultations requisitioned, including those accepted and declined by the patient; and

(iv) interactions with other databases such as the Alberta Electronic Health Record (Netcare).

(b) Information pertaining to the consent process;

(c) a cumulative patient profile (CPP) contextual to the physician-patient relationship (the longer and more complex the relationship the more extensive should be the record) detailing:

(i) patient identification (i.e., name, address, phone number, personal health number, contact person in case of emergencies);

Terms used in the Standards of Practice:

• "Regulated member" means any person who is registered or who is required to be registered as a member of this College. The College regulates physicians, surgeons and osteopaths.

• "Must" refers to a mandatory requirement.

• "May" means that the physician may exercise reasonable discretion.

• "Patient" includes, where applicable, the patient’s legal guardian or substitute decision maker.
(ii) current medications and treatments, including complementary and alternative therapies;

(iii) allergies and drug reactions;

(iv) ongoing health conditions and identified risk factors;

(v) medical history, including family medical history;

(vi) social history (e.g., occupation, life events, habits);

(vii) health maintenance plans (immunizations, disease surveillance, screening tests); and

(viii) date the CPP was last updated;

(d) laboratory, imaging, pathology and consultation reports;

(e) operative records, procedural records and discharge summaries;

(f) any communication with the patient concerning the patient’s medical care, including unplanned face-to-face contacts;

(g) a six-year history of patient billing encounter data as required by Alberta Health (identifying type of service, date of service and fee(s) charged); and

(h) a record of missed and/or cancelled appointments.

(3) Notwithstanding clause (2) a regulated member may indicate that the required documents are available in Netcare or other database that can be reliably accessed for the length of time the record must be maintained.

(4) A regulated member may amend or correct a patient record in accordance with the Health Information Act (HIA) through an initialed and dated addendum or tracked change including the following circumstances:

(a) the correction or amendment is routine in nature, such as a change in name or contact information;

(b) to ensure the accuracy of the information documented; or

(c) at the request of a patient identifying incomplete or inaccurate information.

(5) Notwithstanding (4c), a regulated member may refuse to make a requested correction or amendment to a patient record in accordance with Health Information Act.

(6) A regulated member may append additional information to a patient record in accordance with the HIA.

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