Chapter Chir 11

PATIENT RECORDS

Chir 11.01 Definition. As used in this chapter "patient record" means patient health care records as defined under s. 146.81 (4), Stats.

History: Cr. Register, May, 1997, No. 497, eff. 6–1–97.

Chir 11.02 Patient record contents. (1) Complete and comprehensive patient records shall be created and maintained by a chiropractor for every patient with whom the chiropractor consults, examines or treats.

(2) Patient records shall be maintained for a minimum period of 7 years as specified in s. Chir 6.02 (27).

(3) Patient records shall be prepared in substantial compliance with the requirements of this chapter.

(4) Patient records shall be complete and sufficiently legible to be understandable to health care professionals generally familiar with chiropractic practice, procedures and nomenclature.

(5) Patient records shall include documentation of informed consent of the patient, or the parent or guardian of any patient under the age of 18, for examination, diagnostic testing and treatment.

(6) Rationale for diagnostic testing, treatment or other ancillary services shall be documented in or readily inferred from the patient record.

(7) Significant, relevant patient health risk factors shall be identified and documented in the patient record.

(8) Each entry in the patient record shall be dated and shall identify the chiropractor, chiropractic assistant or other person making the entry.

Note: Chiropractors should be aware that federal requirements, especially in the Health Insurance Portability and Accountability Act of 1996 (HIPAA), may have an impact on record–keeping requirements.

History: Cr. Register, May, 1997, No. 497, eff. 6–1–97.

Chir 11.03 Initial patient presentation. Upon presentation of a new patient, patient records shall contain the following essential elements as relevant or applicable to the evaluation and treatment of the patient:

(1) History of the present illness or complaints, and significant past health, medical and social history.

(2) Significant family medical history and health factors which may be congenital or familial in nature.

(3) Review of patient systems, including cardiovascular, respiratory, musculoskeletal, integumentary and neurologic.

(4) Results of physical examination and diagnostic testing focusing on areas pertinent to the patient's chief complaints.

(5) Assessment or diagnostic impression of the patient's condition.

(6) Treatment plan for the patient, including all treatments rendered, and all other ancillary procedures or services rendered or recommended.

History: Cr. Register, May, 1997, No. 497, eff. 6–1–97.

Chir 11.04 Daily notes. For patient visits in which the chiropractor carries out a previously devised treatment plan, daily notes shall be made and maintained documenting all treatments and services rendered, and any significant changes in the subjective presentation, objective findings, assessment or treatment plan for the patient.

History: Cr. Register, May, 1997, No. 497, eff. 6–1–97.