
STRUCTURE OF THE UVA MEDICAL RECORD

What is included in the UVa medical record?

- Epic documentation (e.g. created/resulted in Epic)
- Approved clinical forms (consents – including research, waivers, downtime forms, etc.)
- Patient administrative forms (FMLA, pre-authorizations, etc.) *Note: Sender must apply a Patient Administrative document type label*
- Transcribed documents (from M*Modal or ChartScript)
- Approved ancillary system documentation (either interfaced or scanned)
- Identified – unapproved documentation for 30 days post HIS notification (HIS Miscellaneous)
- Approved research/clinical trial documentation (consents, orders, results, clinical notes)
- Approved outside facility documentation
 - Pre-hospital (transport)
 - Letters with clinical data
 - Transfer/hand-off of care
 - Radiology reports
 - Emergency room/department reports
 - Discharge summaries
 - Operative/Procedure reports
 - Ambulatory reports (aka Clinic or Progress reports)
 - History & physical's
 - Consultation reports
 - Laboratory/Pathology reports (final, not preliminary)
 - EKG's
 - Vaccinations
 - Outside facility documentation designated by the sender with an approved “granular” outside facility barcode

What is not included in the UVa medical record?

- Non-clinical documentation
- Unapproved clinical forms (including retired)
- Inappropriate media (e.g. paper towels, envelopes, etc.)
- Illegible documentation (even on approved forms)
- Non-English documentation/forms (e.g. lacking English translation on same page)
- Reprints from UVa Epic (even if written upon)
- Unapproved research/clinical trial documentation (e.g. non-Epic, protocols, non-clinical, etc.)
- Miscellaneous documentation (e.g. mortgage or utilize documentation, FAQ's, charitable organizations, etc.)
- Neuropsychiatric testing materials (e.g. IQ tests, etc.)
- Non-approved financial documentation

- Other as identified
- Unapproved outside facility documentation
 - Incident reports (e.g. nursing homes, etc.)
 - Registration cards
 - Discharge instructions/After-visit summaries
 - Progress notes
 - Flow sheets
 - Face sheets
 - Fax cover sheets
 - Billing sheets/Encounter forms
 - Medication lists
 - Care plans (preventative)
 - Prescription data
 - Orders
 - Referrals

Applicable Medical Center Policies:

- Medical Center Policy 0094 – Documentation of Patient Care (Electronic Medical Record)
- Medical Center Policy 0218 – Definition, Characteristics, Authentication and Maintenance of the Medical Record and Designated Record Set
- Medical Center Policy 0266 – Record Management/Document Retention and Destruction

Record Retention:

- UVa medical record documentation
 - Adults – 10 years from the last date of service
 - Minors – 18 years from birth + 10 years from the last date of service
- Outside facility documentation
 - Outside Facility Scan document type* – 2 years from scan date
 - All other Outside Facility document types – 7 years from scan date (as of 9/28/16)

*All approved outside facility documentation is indexed to the Outside Facility Scan document type unless the sender applies a barcode designating an approved UVa Outside Facility document type (excluding legal documentation, Advance Directives, etc).

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