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
  o Incident reports (e.g. nursing homes, etc.)
  o Registration cards
  o Discharge instructions/After-visit summaries
  o Progress notes
  o Flow sheets
  o Face sheets
  o Fax cover sheets
  o Billing sheets/Encounter forms
  o Medication lists
  o Care plans (preventative)
  o Prescription data
  o Orders
  o 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
  o Adults – 10 years from the last date of service
  o Minors – 18 years from birth + 10 years from the last date of service

• Outside facility documentation
  o Outside Facility Scan document type* – 2 years from scan date
  o 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).

Contact: Jeanette Baber – jad7v@virginia.edu or 924-0494