CLIENT CHART (HEALTH RECORD) ORDER – ACUTE

Green font=Obstetrical chart order

Coloured title sections align with chart tab colours

ADVANCE CARE PLANS (filed on left side of record post discharge when signed)
SIGNATURE LOG may be placed here on the Unit and moved to the bottom post discharge.
ADMISSION/LEGAL FORMS
Admission forms, VPP, Clinical Circumstance
Billing Sheet (Temporary Blue- BTHC, Yellow-BRHC –keep at front binder)
Registration of Death (copy)/**Stillbirth Registration/**Notification of Death/COVID -19 Discharge or Death Form/Consent for Autopsy/ Authorization for release Stillborn
Tissue Bank
Birth registration (copy)
Patient Discharge Teaching/ Instructions i.e. anesthesia, surgery
Discharge Instruction Record: Emergency Department/Discharge Medication Plan and Prescription
Home Care forms (internal) /Manitoba Health Home Care
Manitoba Health Application/Assessment for Long Term Care (panel)
Admission/Separation Form for Long Term Care Facility & Respite Care Inpatient Rehab Unit Referral/Patient Reclassification
Alternate Level of Care (ALC) Forms
Ambulance Patient Care Report including Interfacility Transfers/ Manitoba Information Transfer Referral Form
Child & Family Services Apprehension Notification
Notice of Maternity
Request to Register a Child in a Hyphenated or Combined Name/Statuatory Declaration of a Married Woman
Perinatal Loss Release Form
Mental Health Act Forms: Involuntary Medical exam/Involuntary Psychiatric Assessment Certificate of Incapacity/Physician Statement – person no longer capable to manage property Mental health declaration/application forms
Palliative Referral/Registration Form/Palliative Care Symptom Assessment Record/Palliative Care Assessment/Palliative Volunteer Forms
PRESCRIBER ORDERS (white tab)
Best Possible Medication History (BPMH) and Admission Reconciliation & Order Form
Prescriber Orders
Chemo Medication Orders/Chemo Progress notes
Preadmission Orders
Standard Orders
HISTORY/CONSULTS
History & Physical forms, Initial Assessments
Manitoba Prenatal Record, Maternal Database
SBAR Admission/Transfer Reconciliation and Order Form
Adult Nursing Admission History Assessment Form
Triage and Emergency Department Record/EDIS Documents
Antibiotic Resistant Organisms (AROs) MRSA and VRE Admission Screening
Preoperative Assessment Patient Questionnaire / Pre-op/OR checklists
Sepsis – Severe/Septic Shock Recognition and Diagnosis Algorithm
Assessments

Referrals- Medical Correspondence
Consultations i.e. Anesthetic
IPN/CARE MAPS
Care Maps
Integrated Progress Notes (IPN), TPN, Resuscitation Record
Breastfeeding Plan Term
Labour Record
Birth Summary
Education: Teaching Record for Patients receiving Specific Care
CHARTING FLOW SHEETS
Flowsheets
Wound Assessment Treatment Form
Braden Scale for Predicting Risk of Pressure Injuries/ Pressure and Management Checklist
Clinical Record/ Critical Care record
Frequent Monitoring Record (**Vital signs**)
ICU Monitor Telemetry/Ventilator
Neurological Assessment Record and Neurological Behavioural Status Exam
Treatment Record
Restraints Safety Check List
OPERATIVE RECORDS
Consent to Procedure, Treatment or Investigation, Preo op assessments, anesthetic records
Epidural Continous Infusion monitoring **Induction Checklist**
Intrathecal Narcotic Flowsheet /Continuous Epidural Infusion Monitoring
Operative Report/OR Logging Record
Pathology/OR photos/Biopsy Reports
Estrogen Receptors/Dental Certificate
Surgical Count Procedure List, Sponge and Instrument
Procedural Sedation Record/Intraoperative nurses notes
Recovery Room Record/ Post Anesthetic Care Unit
OR reports of procedures done at other facilities
Canadian Joint Replacement Registry Form
Colonoscopy Reporting Form/Post colonscopy screening and surveillance recommendation
PICC line insertion form/central line checklist/Surgical Safety Checklist
BLOOD PRODUCTS
Canadian Blood Services (CBS) Requests/Reports/Cumulative Blood Product Record
Transfusion Medicine Results Report / RH Immunoglobulin Treatment Slip/forms
LABORATORY
Blood, MRSA, Urine, Stool
DIAGNOSTICS
X-ray, CT Scan, MRI, ultrasound reports
Angiogram, Angioplasty, Cardiac Catheterization reports, Echocardiogram, EEG, EKG
Rhythm strips, Holter Monitor Report, Stress test
Spirometry Report, Pulmonary Function Test/Oximetry
Telemetry Requisition and Order Sheet/Volume Ventilation Monitoring
MEDICATIONS
Medication Administration Record (MAR) Standing orders PRN/Scheduled/Non-recurring,
FLUID BALANCE (Intake and Output)
MISCELLANEOUS
CONSENTS/ Waivers (excluding surgical consents- file in Operative Record section)
Alcohol Withdrawal Scale/Mini Mental Status, Infection Control Surveillience,
Valuables Envelope
Signature Record after discharge
KARDEX -Medication kardex/Care Plan
Transfer information from other facilities/Fax confirmation sheets from the Units

NEWBORN
Neonatal Transport Team Record
Newborn Care Standard Orders/Maternal Neonatal Death Standard Orders
Hypoglycemia management in the Neonate Assessment
Universal Newborn Hearing Screening Program Referral
Newborn Care Map/Newborn Extension Care Map
Neonatal Resuscitation Record
Discharge Information Newborn Jaundice
Newborn Abstinence Scoring System
Newborn Care Flowsheet /Infant Loss Patient Care Flowsheet
Newborn Feeding Record
Newborn Frequent Monitioring Record
Newborn Screening Report