Southern Health Santé Sud

CLIENT CHART (HEALTH RECORD) ORDER – PERSONAL CARE HOME AND TRANSITIONAL CARE CENTRES

Highlighted titled sections below align with the order of the 14 titled tabs (dividers) located in client chart binder

CLIENT CHART (HEALTH RECORD) ORDER
In plastic sleeve in the front of the binder:
Resident Medical Problem List
Pacemaker information
Resident Information for Health Record
Code Yellow form
ADVANCE CARE PLANS
Advance Care Planning – Goals of Care Form
Health Care Directive (if the resident has one)
Power of Attorney (if the resident has one, most current copy only)
Order of Committeeship/Public Trustee
Death forms if resident dies in Personal Care Home
ORDERS
Prescriber orders
Standard orders
Best Possible Medication History (BPMH)
Care Maps i.e. UTI
Medication reviews
TRANSFER AND DISCHARGE
Manitoba Transfer Information Referral Form
PCR Reports (EMS Forms)
Transfer and Discharge Summaries
Emergency Department/Outpatient Records
Wound and Skin Discharge Summary Forms
INTEGRATED PROGRESS NOTES
Integrated Progress Notes
Quarterly Reviews
Annual Care Conference
ASSESSSMENTS
Clinical Records (vital signs, glucose monitoring, diabetic record, intake/output, stocking measurements, etc.)
Braden Scale for Predicting Pressure Injuries
Pressure Injury Prevention and Management Intervention Checklist
Health Care Aide Skin Observation Form
Wound Assessment and Treatment Form
Wound photos
Turning and Positioning Flow Sheet
Multidisciplinary Team Pressure Injury Safety Huddle Form
Transfer and Mobility Assessment (SCHIPP)

TTMD Feeding and Swallowing Screening Form
Violence Prevention Screening Form
Nutritional Screen
Three day food records
Edmonton Symptom Assessment System-revised (ESAS-r)
Edmonton Symptom Assessment System-revised (ESAS-r) Graph
Behaviour mapping
Cognitive screening (e.g. MMSE, MOCA)
PIECES forms
Antibiotic resistance screening
Smoking history/assessment tool
Neurological assessment
Foot assessment
Oral health assessment
Suicide Risk Screening
Geriatric Depression Scale/SIG E CAPS depression scale
Resident activity participation record
MEDICATION/TREATMENT
Medication Administration Records
Medication patch records
Insulin records
Exceptional Drug Status Forms (e.g. cholinesterase)
Treatment Record
PCH Delivery of Care Records
RESTRAINTS/FALLS
Restraint documentation as per policy
Falls documentation as per policy
HISTORY/PHYSICAL
Medical history
History & Physical exam (every two years)
DIAGNOSTICS
Radiology reports
EKG
Lab reports
ADMISSION RECORDS
Initial care plan
Integrated Assessment
Inter-ocular lens
Pre-admission forms (e.g. acceptance letters, notes of pre-admission contact, home visit etc.)
Resident agreement
Application/Assessment for Long Term Care
Dependency level
Admission checklist
CONSULTS
Palliative Care Referral Form
Pastoral/Spiritual Care
Seniors Consultation Team Referral
Therapy Referrals (e.g. OT, PT, , wound care, music, etc.)

REHAB & THERAPY
Power mobility device contract
Rental/Service agreements
CONSENTS
Consent for treatment
Consent for disclosure and record of release
Agreement to share personal health information
External services consents
Immunization consents
Influenza consent
Acknowledgement consent (e.g. fridge agreement, Enhanced Living Unit Agreement etc.)
MISCELLANEOUS
Integrated Care Plans (not current)
Veterans Affairs Canada communications
Letters to family
External service providers
Photocopy eyeglasses
GST exemption
Master Signature Sheet