10A NCAC 13B .4107 EMERGENCY RECORDS

(a) The facility shall require all levels of emergency departments to maintain a continuous control register on each patient seen for services which shall include at least the name, age, sex, date, time, and means of arrival, nature of complaint, disposition, and time of discharge.

(b) The facility shall maintain a record for each patient seeking emergency care. This shall include:

(1) patient identification, time and means of arrival;
(2) pertinent history and physical findings and patient vital signs;
(3) diagnostic and therapeutic orders;
(4) clinical observations including results of treatment;
(5) reports of procedures, tests and results;
(6) diagnostic impression; and
(7) discharge or transfer summary of treatment including final disposition, the patient's condition, and any instructions given to the patient and or family for follow-up care.

History Note: *Authority G.S. 131E-79;*
Eff. January 1, 1996;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. July 22, 2017.