10A NCAC 27G .0206 CLIENT RECORDS

(a) A client record shall be maintained for each individual admitted to the facility, which shall contain, but need not be limited to:

(1) an identification face sheet which includes:
  (A) name (last, first, middle, maiden);
  (B) client record number;
  (C) date of birth;
  (D) race, gender and marital status;
  (E) admission date;
  (F) discharge date;
(2) documentation of mental illness, developmental disabilities or substance abuse diagnosis coded according to DSM IV;
(3) documentation of the screening and assessment;
(4) treatment/habilitation or service plan;
(5) emergency information for each client which shall include the name, address and telephone number of the person to be contacted in case of sudden illness or accident and the name, address and telephone number of the client's preferred physician;
(6) a signed statement from the client or legally responsible person granting permission to seek emergency care from a hospital or physician;
(7) documentation of services provided;
(8) documentation of progress toward outcomes;
(9) if applicable:
  (A) documentation of physical disorders diagnosis according to International Classification of Diseases (ICD-9-CM);
  (B) medication orders;
  (C) orders and copies of lab tests; and
  (D) documentation of medication and administration errors and adverse drug reactions.

(b) Each facility shall ensure that information relative to AIDS or related conditions is disclosed only in accordance with the communicable disease laws as specified in G.S. 130A-143.

History Note: *Authority G.S. 122C-26; 143B-147;*
Eff. May 1, 1996;
Recodified from 10 NCAC 14V .0204 to 10 NCAC 14V .0206 Eff. January 3, 2001;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. July 20, 2019.