**Section 390.1620 Content of Medical Records**

a) No later than the time of admission, the facility shall enter the following information onto the identification sheet or admission sheet for each resident:

1) Name, sex, date of birth and Social Security Number,

2) Whether the resident has been previously admitted to the facility,

3) Date of current admission to the facility,

4) State or country of birth,

5) Religious affiliation (if any),

6) Name, address and telephone number of any referral agency, state hospital, zone center or hospital from which the resident has been transferred (if applicable),

7) Name and telephone number of the resident's personal physician.

8) Name and telephone number of the resident's next of kin or responsible relative,

9) Race and origin,

10) Father's name and mother's maiden name, Social Security numbers, birthplaces, address and marital status of resident's parents,

11) Name, address and telephone number of the resident's dentist, and

12) The diagnosis applicable at the time of admission.

b) The following information shall be obtained and entered in the resident's record at the time of admission:

1) Height, weight, color of hair and eyes, and identifying marks, and recent photograph,

2) Reason for admission of referral, as well as any prognosis that is available,

3) Type and legal status of admission,

4) Legal competency status,

5) Language spoken or understood,

6) Results of the preadmission evaluation conducted pursuant to Section 390.630(a) of this Part, previous histories and any other previous evaluations available.

7) At the time of admission, the facility shall obtain a history of prescription and non-prescription medications taken by the resident during the 30 days prior to admission to the facility (if available).

c) Within 14 days of admission, each resident's record shall contain an individual habilitation plan which shall be reviewed and updated in accordance with the requirements specified in Section 390.1010(c) of this Part.

d) Within one month of admission, each resident's record shall contain a statement of prognosis that can be used for programming and placement.

e) In addition to the information that is specified above, each resident's medical record shall contain the following:

1) Medical history and physical examination form that includes conditions for which medications have been prescribed, physician findings, all known diagnoses and prognosis, if available. This shall describe those known conditions that the medical and resident care staff should be apprised of regarding the resident. Examples of diagnoses and conditions that are to be included are allergies, epilepsy, diabetes and asthma.

2) A physician's order sheet that includes orders for all medications, treatments, therapy and habilitation services, diet, activities and special procedures or orders required for the safety and well-being of the resident.

3) Nurse's notes that describe the nursing care provided, observations and assessment of symptoms, reactions to treatments and medications, progression toward or regression from each resident's established goals, and changes in the resident's physical or emotional condition. (B)

4) An ongoing record of notations describing significant observations or developments regarding each resident's condition and response to treatments and programs.

A) Physicians and other consultants who provide direct care or treatment to residents shall make notations at the time of each visit with a resident.

B) Significant observations or developments regarding resident responses to activity programs, social services, dietary services, work programs and nursing and personal care shall be recorded as they are noted. If no significant observations or developments are noted for a month, an entry shall be made in the record of that fact.

5) Any laboratory and x-ray reports ordered by the resident's physician.

6) Documentation of visits to the resident by a physician and to the physician's office by the resident. The physician shall record, or dictate and sign, the results of such visits, such as changes in medication, observations and recommendations made by the physician during the visits, in the record.

7) The results of the physical examination conducted pursuant to Section 390.1030(f) of this Part.

8) Upon admission from a hospital or state facility, a hospital summary sheet or transfer form that includes the hospital diagnosis and treatment, and a discharge summary. This transfer information, which may be included in the transfer agreement, shall be signed by the physician who attended the resident while in the hospital.

9) Reports of overall reviews and evaluations of each resident's individualized program plan. These reports shall identify the developmental progress and status of each resident, and shall be completed at least semi-annually by each professional discipline providing services to the resident.

10) Any correspondence pertaining to the resident's program.

11) Records of significant behavior incidents, reactions to any family visits and contacts, and attendance at programs.

12) An update of the information recorded at the time of admission. This update shall be performed at least once every 12 months, with changes in information relevant to the resident's personal physician and responsible relative to be recorded as they occur.

13) Appropriate authorizations and consents.

14) Weekly record of resident's weight, unless a different interval is ordered by the physician.

15) Records on leaves and temporary transfers, which shall include date, time, condition of resident, to whom released, planned destination, anticipated date of return, and any special instructions on medication dispensed.

(Source: Amended at 13 Ill. Reg. 6301, effective April 17, 1989)