A. Policy Statement

Medical records of Office of Mental Health (OMH) State operated facilities are hybrid records, consisting of both paper and electronic documents and utilizing both manual and electronic processes. The term "medical record" is broadly defined to refer to a collection of information about a patient, and includes comprehensive information about clinical, administrative and legal aspects of a patient's care and treatment.

The medical record serves a number of functions related to the provision of care and treatment. The primary function is to facilitate the planning and delivery of integrated quality care and treatment. It provides a comprehensive base of information about a patient's prior history, current functioning and the provision of care and treatment to the full range of staff involved with the treatment of the patient.

The medical record is also used to evaluate and make determinations about the quality of care and treatment provided. Since many reviews are carried out retrospectively, information contained in the medical record is a primary source of assessing the adequacy of the care and treatment provided to individual patients, within a unit, program, facility or throughout the state facility system.

The medical record can also provide a source of information which may be useful in resolving legal issues concerning the patient, staff or OMH, and to implement patient related activities such as quality assurance monitoring, planning, budgeting and activities necessary for payment to be made to or on behalf of patients.

The medical record is comprised of two distinct components: (1) the Legal Medical Record; and (2) the Designated Record Set. The Legal Medical Record is the compilation of information that is released for legal proceedings or in response to authorized requests for medical records (pursuant to HIPAA and Mental Hygiene Law Section 33.13). The Designated Record Set represents a greater scope of information that is available to a patient under the right to access records established in HIPAA and Mental Hygiene Law Section 33.16. *Quality assurance information and a patient's Education Record are excluded from both the Legal Medical Record and the Designated Record Set.*

This policy directive establishes general requirements pertaining to medical records of OMH State operated facilities. It also specifically identifies the information that comprises both components of a patient's medical record. It is intended to establish standards for the

contents, maintenance, and confidentiality of patient medical records that meet the requirements set forth in both federal and New York State laws and regulations. It fully supersedes the former QA-400, Uniform Case Record. Please review Appendix A for UCR details.

B. Relevant Statutes and Standards

NYS Mental Hygiene Law (MHL) §33.13, Clinical Records; Confidentiality
MHL §33.16, Access to Clinical Records
NYS Technology Law §103, Functions, Powers and Duties of the Office
NYS Technology Law §104, Advisory Council for Technology
NYS Technology Law §105, Functions, Powers and Duties of the Council
NYS Technology Law §107, Severability
9 NYCRR Part 540, Electronic Signatures and Records Act
OMH Official Policy OM-740, Records Retention Periods
OMH Privacy Policy Manual
CITER's Information Security Policy
42 CFR Part 2, Confidentiality of Substance Use Disorder Patient Records
New York Public Health Law 27-F, HIV and AIDS Related Information
42 CFR § 482.24, Condition of Participation: Medical Record Services
45 CFR Part 160, General Administrative Requirements
45 CFR Part 164, Security and Privacy
Joint Commission Standards

C. Definitions

1. *Authentication* means the process that ensures that users are who they say they are, in order to prevent unauthorized people from accessing data or using another person's identity to sign documents.

2. *Copy Functionality* means the ability to electronically move documentation from one part of a record to another part of the same or a different record and shall include any of the following techniques: copy and paste, cloning, copy forward, re-use, carry forward, or save note as a template.

3. *Designated Record Set (DRS)* means a group of records that include protected health information (PHI) and that is maintained, collected, used or disseminated by, or for, a covered entity for each individual that receives care from a covered entity but *excluding* quality assurance information (i.e., the incident report and all supporting investigation documents) and the Education Record. The DRS includes:

   (a) The legal medical record and billing records about individuals maintained by or for a covered health care provider;

(b) The enrollment, payment, claims adjudication, and case or medical management record systems maintained by or for a health plan; or

(c) The information used, in part or in whole, to make decisions about individuals.

4. *Legal Medical Record* means the collection of information, regardless of format, concerning a patient and his or her health and/or behavioral health care that is created and maintained in the regular course of OMH facility business, in accordance with OMH policies, made by a person who has knowledge of the acts, events, opinion or diagnoses relating to the patient, and made at or around the time indicated in the documentation but *excluding* quality assurance information (i.e., the incident report and all supporting investigation documents) and the Education Record.

5. *Medical Record* means the collection of information, regardless of form or format, on all matters relating to the admission, legal status, care, and treatment of a patient, including all pertinent documents relating to the patient, but *excluding* quality assurance information (i.e., the incident report and all supporting investigation documents) and the Education Record. The term "medical record" shall mean and include the term "clinical record," as such term is used and defined in New York State Mental Hygiene Law Sections 33.13 and 33.16.

6. *Protected Health Information ("PHI")* means individually identifiable health information that is transmitted or maintained in any medium, including verbal statements.

7. *Signature* means a signature which, regardless of format, identifies the author or the responsible party who takes ownership of and attests to the information contained in a record entry or document.

8. *Source information or data* means data, reports or findings upon which clinical interpretations or decision making are based (e.g., clinical assessments or tests; or written results of a test such as an X-ray, an ECG, or other similar procedures).

9. *Workforce Members* means employees, volunteers, trainees, clinicians serving under contracts with facilities, and other persons whose conduct, in the performance of work for the Office, including its programs or facilities, is under the direct control of the Office of Mental Health, regardless of whether or not they are paid by the Office.

D. Body of the Directive

This policy directive consists of 14 parts:

1. Maintenance of the Medical Record
2. Confidentiality and Security
3. Content Standards

4. Legal Medical Record vs. Designated Record Set
5. Completion, Timeliness and Authentication of Medical Records
6. Routine Requests for Medical Records for Purposes of Treatment, Payment and Healthcare Operations
7. Requests for Electronic Components of the Medical Record
8. Ownership, Responsibility and Security of Medical Records
9. Retention and Destruction of Medical Records
10. Maintenance and Legibility of Record
11. Corrections and Amendments to Records
12. Use of Copy Functionality for Documentation within the Medical Record
13. Parts of the Legal Medical Record
14. Information Not Considered Part of the Legal Medical Record

1) ***Maintenance of the Medical Record***

(a) A medical record shall be maintained for every individual who is evaluated or treated as an inpatient, outpatient, or residential patient of an OMH hospital, clinic, or program.

(b) The medical record may be a hybrid record, consisting of both electronic and paper documentation.

(c) The medical record contents can be maintained in either paper (hardcopy) or electronic formats, including digital images, and can include patient identifiable source information, such as photographs, films, digital images, and/or a written or dictated summary or interpretation of findings.

(d) The current electronic components of the medical record consist of patient information from multiple electronic medical record source systems. The intent of OMH is to integrate all electronic documents into an electronic repository.

(e) Original medical record documentation must be sent to the designated medical records department. Whenever possible, the paper chart shall contain original reports.

2) ***Confidentiality and Security***

(a) The medical record is confidential and is protected from unauthorized disclosure by law, including but not limited to Mental Hygiene Law Section 33.13 and 45 CFR Parts 160, 164 (HIPAA Privacy and Security Regulations).

(b) The circumstances and methods under which OMH may use and disclose confidential information from the medical record is set forth in the OMH Privacy Policy Manual and the CITERs Information Security Policy.

(c) Any disclosures of the medical record shall be limited to that information necessary in light of the reason for the disclosure (i.e., the "minimum necessary rule").

(d) Information disclosed from the medical record shall be kept confidential by the party receiving such information, and the limitations on disclosure (as set forth in Mental Hygiene Law Section 33.13 and the OMH Privacy Policy Manual) shall apply to such party.

3) ***Content Standards***

(a) Medical record content shall meet all State and Federal legal, regulatory and accreditation requirements including but not limited to the Medicare Conditions of Participation 42 CFR Section 482.24[1] and standards of the Joint Commission.

(b) Each medical record shall contain sufficient, accurate information to identify the patient; support the diagnosis/condition; justify the care; treatment, and services; document the course and results of care, treatment, and services; and promote continuity of care among health and behavioral health care providers. The information may be from any source and in any format, including, but not limited to print medium, audio/visual recording, and/or electronic display.

(c) The medical records of all OMH programs must comply with applicable facility policies and procedures, as well as Medical Staff Bylaws, for content and timely completion. Such medical records must also be consistent with any applicable OMH guidelines.

(d) All documentation and entries into the medical record, both paper and electronic, should include the patient's full name and a unique facility medical record number, and date of birth. Each page of double-sided or multi-page forms must be marked with both the patient's full name and the unique medical record number, since single pages may be photocopied, faxed or imaged and separated from the whole.

(e) All medical record entries should be made as soon as possible after the care is provided, or an event or observation is made. An entry should never be made in the medical record in advance of the service provided to the patient. Pre-dating or backdating an entry is prohibited.

[1] Appendix A contains a listing of required medical record documentation content, and current electronic or paper format status.

4) ***Legal Medical Record vs. Designated Record Set***

(a) *Legal Medical Record*: The Legal Medical Record is a subset of the Designated Record Set and is the record that will be released for legal proceedings or in response to a request to release patient medical records under HIPAA and Mental Hygiene Law Section 33.13. The Legal Medical Record includes information pertaining to screening and admission; legal status; assessment and diagnosis; treatment planning, physical and medical data; treatment progress; and discharge[2].

(b) *Designated Record Set:* Under the HIPAA Privacy Rule, an individual has the right to access and/or amend his or her protected health information that is contained in a "Designated Record Set." The term "Designated Record Set" is defined within the Privacy Rule to include medical and billing records, and any other records used by the provider to make decisions about an individual[3]. In accordance with the HIPAA Privacy Rule, OMH has defined a "Designated Record Set" to mean the group of records maintained for each individual who receives healthcare services delivered by a healthcare provider, which is comprised of the following elements:

(i) The Legal Medical Record, whether in paper or electronic format;

(ii) Billing records including claim information; and

(iii) Other information contained in the medical record (whether in paper or electronic format), if such information was used to make treatment decisions about the patient and has not otherwise been incorporated in the Legal Medical Record.

(c) The Legal Medical Record can reference or summarize information obtained from records of non-OMH providers (e.g., health information that was not documented during the normal course of business at an OMH facility, clinic, or program). However, documents or records created by non-OMH providers are themselves not considered part of the Legal Medical Record, since they may be subject to re-disclosure prohibitions and OMH cannot confirm the accuracy or completeness of such external records.

(d) If information from another provider or healthcare facility, or personal medical record, is used in providing patient care or making medical decisions, it is considered part of the Designated Record Set.

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[2] The Legal Medical Record includes all information that would formerly be considered the "active" section of the Uniform Case Record.

[3] The Designated Record Set includes all information that would formerly be considered the "active and 'inactive" sections of the Uniform Case Record.

5) ***Completion, Timeliness and Authentication of Medical Records***

(a) All inpatient medical records must be completed within 30 days from the date of discharge. Additional requirements may be included in applicable facility policy/procedures and Medical Staff By-Laws.

(b) All medical record entries are to be authenticated with a signature, title, date and time.

(c) Certain electronic methods of authenticating the medical record, including methods such as passwords, access codes, tokens, or key cards may be allowed provided certain requirements are met. The methodology for authenticating the document electronically must comply with New York State Electronic Signatures and Records Act (NYS Technology Law §§103, 104, 105 and 107) and implementing regulations at 9 NYCRR Part 540, and this policy.

(d) Fax signatures are acceptable, for release of information authorization purposes, but are not acceptable for original chart documents. Efforts should be made to verify signature whenever possible.

(e) No document intended for retention in a medical record should be stored electronically in an unprotected readable/writable format (e.g., MS Word) that permits alteration after the document has been printed, signed, and filed.

6) ***Routine Requests for Medical Records for Purposes of Treatment, Payment and Healthcare Operations***

(a) Facility Health Information Management staff will process routine requests for medical records. All charts physically removed from the medical record storage areas will be logged, including the date and location where they are forwarded (e.g., using a card file or computerized tracking system).

** All charts physically removed from the inpatient unit chart racks/room will be signed out on a log sheet, including the date and location where they are being utilized. (e.g., using a log or book.) The chart must be returned prior to end of shift or communication to next sheet of extension.

(b) Only authorized OMH Workforce members may directly access medical records in accordance with the OMH Privacy and Security Policies. Workforce members, who access medical records for payment or healthcare operations are responsible for accessing only the amount of information which is necessary to complete job responsibilities.

(c) Access to medical records by OMH Workforce members shall be in accordance with

the following:

(i) Treatment Purposes: Facility clinical staff responsible for providing direct care to a patient may access the full medical record, as necessary to provide care.

(ii) Payment Purposes: Authorized facility workforce members may access the patient's medical record for purposes of obtaining payment for services, including the following uses:

a. coding and abstracting;
b. billing including claims preparation, claims adjudication and substantiation of services;
c. utilization review; and
d. third party payer reviews (including quality improvement organization reviews).

(iii) Healthcare Operations: Patient medical records may be accessed for routine healthcare operation purposes, including, but not limited to:

a. peer review activities;
b. quality management reviews and investigations;
c. clinical and legal documentation reviews;
d. auditing activities;
e. credentialing and certification activities; and
f. teaching.

(d) Physical location of the record exception:

(i) When providing requested records to the Court, original records should not be sent.

(ii) Where a subpoena or order requests an original record, OMH Counsel's office should be promptly contacted to arrange with the court the acceptance of a certified copy of the record to meet the Court's needs.

7) ***Requests for Electronic Components of the Medical Record***

Personnel who access the electronic medical record are required to have a unique User ID and access code. Access to information is limited according to the minimum necessary rule and managed by role (i.e., "need to know"), as approved by designated management personnel.

8) ***Ownership, Responsibility and Security of Medical Records***

(a) All medical records of OMH patients, regardless of whether they are created at, or received by, OMH, and patient lists and billing information, are the property of OMH and the State of New York. However, the information contained within the Designated Record Set must be accessible to the patient and thus made available to the patient or his or her personal representative in accordance with Mental Hygiene Law Section 33.16, HIPAA, and the OMH Privacy Policy Manual.

(b) Responsibility for the medical record: The facility Director of Health Information Services is designated as the person responsible for monitoring release and access to patient medical records. The clinical staff and other health care professionals are responsible for preparing, completing, and submitting accurate documentation in the medical record within required and appropriate time frames to support patient care.

(c) Original records may not be removed from OMH facilities and/or offices except by court order or for a mental health hearing. Where a court order requires the original record, promptly contact OMH Counsel's Office who will coordinate with the Court to see if a Certified Copy of the record will meet the Court's needs. If an OMH workforce member separates from or is terminated by OMH for any reason, he or she may not remove any original medical records, patient lists, and/or billing information from OMH facilities and/or offices.

(d) Medical records shall be maintained in a safe and secure area. Safeguards to prevent loss, destruction and tampering will be maintained as appropriate, and in accordance with the CITERs Information Security Policy. Records will be released from Health Information Management Services only in accordance with the provisions of this policy directive and other applicable OMH policies and procedures.

(e) Consistent with the OMH Privacy Policy Manual, special care must be exercised with alcohol and substance abuse records protected by 42 CFR Part 2, HIV/AIDS information protected by Article 27-F of the New York Public Health Law, quality assurance documents, and documents relating to patient and child abuse reporting and investigation.

(f) Chronology is essential and close attention shall be given to assure the integrity of data, that documents are filed properly (in the correct section and date order), and that information is entered in the correct encounter record for the correct patient, including but not limited to when scanning and indexing of imaged documents occurs.

9) ***Retention and Destruction of Medical Records***

All medical records are retained for at least as long as required by State and federal law and regulations, and OMH Official Policy OM-740 (Records Retention). The electronic version of the record must be maintained per the legal retention requirements as specified in OM-740, or as otherwise advised by OMH Counsel's Office.

10. ***Maintenance and Legibility of Record***

(a) All medical records, regardless of form or format, must be maintained in their entirety, and no document or entry may be deleted or expunged from the record, except in accordance with the destruction policy.

(b) Handwritten entries should be made with permanent black or blue ink, with medium point pens. This is to ensure the quality of electronic scanning, photocopying and faxing of the document. All entries in the medical record must be legible to individuals other than the author.

11. ***Corrections and Amendments to Records***

(a) When an error is made in a medical record entry, the original entry must not be obliterated, and the inaccurate information should still be accessible.

(b) General Rules:

(i) Documents created in paper format:

a. Labels shall not be placed over entries for correction of information.

b. If information in a paper record must be corrected or revised, a line shall be drawn through the incorrect entry and the record shall be annotated with the date, time, and the reason for the revision noted, as well as the signature of the person making the revision, provided, however in instances in which the wrong patient's name is in the entry, but the information is correct with respect to the patient of record, the document should be retracted, and a correct copy without the wrong patient's name should be placed in the record, to protect the privacy of the wrong patient. If action has been taken on the wrong patient before the retraction is made, such information must be documented in the record belonging to the wrong patient.

c. If the document was originally created in a paper format, and then scanned electronically, the electronic version must be corrected by printing the documentation, correcting as required for paper records, and rescanning the document in its original location.

(ii) Documents created electronically:

a. In general, correcting an error in an electronic/computerized medical record should follow the same basic principles as corrections to the paper record.

b. The system must have the ability to track corrections or changes to any documentation once it has been entered or authenticated.

c. When correcting or making a change to a signed entry, the original entry must be viewable, the current date and time entered, and the person making the change identified.

d. Alternatively, if an electronic medical record is not equipped to track corrections or changes, than a user may enter an addendum consistent with paragraph 6 of this subdivision for a late entry (i.e., add the addendum, document the date and time of the entry, and state the reason for the correction); provided, however in instances in which the wrong patient's name is in the entry, but, the information is correct with respect to the patient of record, the electronic document should be retracted, and a correct copy without the wrong patient's name should be entered in the record, to protect the privacy of the wrong patient.

e. Preliminary versions of transcribed documents may be edited by the author prior to signing.

f. Once a transcribed document is final, it can only be corrected in the form of an addendum affixed to the final copy. The amended version must be reviewed and signed by the author.

(c) Late Entry: When a pertinent entry was missed or not written in a timely manner, the author must:

(i) Identify the new entry as a "late entry";

(ii) Enter the current date and time, without giving an appearance that the entry was made on a previous date or an earlier time. The entry must be signed;

(iii) Identify or refer to the date and circumstance for which the late entry or addendum is written;

(iv) Document the late entry as soon as possible. There is no time limit for writing a late entry; however, the longer the time lapse, the less reliable the entry becomes.

(d) Addendum: An addendum is another type of late entry that is used to provide additional information in conjunction with a previous entry. An addendum is also the method used to document corrections submitted by patients or their personal representatives in the exercise of the right to request corrections to their medical records. When entering an addendum the author shall:

(i) Document the date and time on which the addendum was made;

(ii) Write "addendum" and state the reason for creating the addendum, referring back to the original entry;

(iii) Complete the addendum as soon as possible after the original note;

(iv) Sign the addendum and attach it to the associated document, provided, however, that in the event the addendum was submitted by the patient or his/her personal representative, it shall be identified as such.

(e) Errors in Scanning Documents: If a document is scanned with wrong encounter date or to the wrong patient, the scanned document must be reprinted, and then rescanned to the correct episode/encounter date or patient. The incorrectly scanned document must be voided in the permanent document repository.

12. ***Use of Copy Functionality for Documentation within the Medical Record***

(a) The use of copy functionality eliminates duplication of effort and saves time but should not become routine; it shall be carefully and judiciously used to ensure accurate documentation. Clinicians engaging in electronic documentation must avoid indiscriminately copying and pasting another provider's progress note, discharge summary, electronic mail communication, or redundant information provided in other parts of the medical record.

(b) Regardless of the method of entry, all clinicians making an entry are responsible for clearly identifying who performed each service documented within the entry. When entering patient data into the medical record that the clinician did not personally take or test, the clinician must attribute the information to the person who did.

(c) Copying from another clinician's entry: Clinicians remain responsible for the total content of their documentation, whether the content is original, copied, pasted, imported, or reused.

(d) Copying for re-use of data: A clinician may use copy functionality to copy and paste entries made in a patient's record during a previous encounter into a current record as long as care is taken to ensure that the information actually applies to the current

visit, that applicable changes are made to variable data, and that any new information is recorded.

(e) Errors in the source entry that are discovered when using copy functionality must be immediately brought to the attention of Health Information Management. All entries from the original source that contain errors must be corrected in accordance with this policy directive.

(f) Clinicians using copy functionality must attend training offered or recommended by OMH prior to his or her initial use of such technology.

13. Parts of the Legal Medical Record

- Administrative records related to patient care, identified in facility guidelines, including but not limited to Admission and Discharge Documents; Acknowledgment of Receipt of Notice of Privacy Practices, Use/Disclosure of PHI Logs, and Patient Movement History;
- Advance directives;
- Allergy records;
- Alerts and reminders;
- Assessments, screenings, and evaluations, including:
    - Psychiatric, nursing, psychological, social work, vocational, rehabilitation, nutrition, choking, falls;
    - Substance Use and Abuse Assessments; and
    - Suicide and Risk Screenings/Assessments.
- Care/treatment plans
- Consent forms for care, treatment, and research;
- Consultation reports;
- Diagnostic images;
- Discharge plans and summaries;
- Graphic records;
- History and physical examination records;
- Immunization records;
- Intake and output records;
- Legal papers related to a patient's care and treatment or legal status, including Legal papers including applications and orders for court retentions, involuntary admission papers, and Criminal Procedure Law 330.20 or 730 examinations;
- Medication administration records;
- Orders for care and treatment, including medication, laboratory tests, and PRN or STAT orders;
- Orders for restraint or seclusion;
- Orders restricting patient rights, as required pursuant to Mental Hygiene Law section 33.02;
- Medication profiles;

- Monitoring forms required by a specific condition (e.g., diabetes, menses, etc.);
- Patient-submitted documentation (including artwork if referenced in the medical record);
- Photographs (digital and analog);
- Progress notes and documentation;
- Records received from another provider directly operated by the Office of Mental Health, if they were relied on to provide care to the patient;
- Speech/occupational therapy records;
- Vital statistics, including temperature, height, weight, and blood pressure monitoring;
- Any other information required by the Medicare Conditions of Participation, New York State statutes or rules, OMH policy, or by any third-party payer as a condition of reimbursement.

14. ***The following are <u>not</u> considered to be part of the Legal Medical Record***:

- Abbreviation and do-not-use abbreviation lists;
- Accreditation reports;
- Audit trails related to the electronic record;
- Best practice guidelines created from aggregate patient data;
- Birth and death certificate worksheets;
- Committee minutes (e.g., forensic, case management, or treatment over objection);
- Correspondence, including:
    - correspondence relating to requests for records;
    - interagency correspondence;
    - oversight agency correspondence; and
    - patient complaints.
- Databases containing patient information;
- Draft documents and work in progress;
- Education records;
- Event history and audit trails;
- Employment indicators located in MHARS;
- Financial and insurance forms, including patient resource records;
- Incident/investigative reports;
- IRB lists;
- List of victims of crimes committed by individuals receiving services from OMH;
- Lists of known individuals that are identified as potential victims of individuals receiving services from OMH;
- Logs;
- ORYX, Quality Indicator, Quality Measure, or other reports;
- Patient-identifiable claims;
- Patient appointment or program schedules;
- Protocols and clinical pathways, practice guidelines, and other knowledge sources that do not imbed patient data;

- Raw data for testing (e.g., psychiatric or psychological evaluations);
- Records from other providers not directly operated by the Office of Mental Health;
- Registries;
- Research records;
- Staff roles and access rights;
- SHAPEMEDs;
- Statistical Reports.

Refer to OM-740 for discharge packet documents or put an indicator after each document included in discharge packet.

Appendix A

Use of Electronic Signature - Electronic Medical Record

All MHARS (or its successor electronic records system) patient forms that require confirmation can be electronically signed. It is a facility decision whether or not to enable a form for electronic signature. This can be done on a form-by-form basis. Once a form is enabled for electronic signature it **must** be electronically signed. In making the decision to use electronic signature, a facility must conform to the following guidelines:

- The facility must follow the New York State Office of Information Technology Services Electronic Signatures and Records Act Guidelines, available at http://www.its.ny.gov/policy/G04-001/NYS-G04-001.pdf.

- The person completing the form must sign into the electronic medical record (EMR) under his/her own name and not under the name of the person who is responsible for electronically signing the form. No one may sign into the (EMR) using someone else's identification.

- If a form is completed by an individual other than the signatory, the person actually signing it must subsequently sign into the application, access it and electronically sign it.

- During active treatment, forms that are electronically signed can be stored electronically in the EMR database (i.e., not printed and placed in the paper chart). Alternatively, they can be electronically signed, printed and placed in the chart.

- The facility can decide to electronically sign and print some forms while other forms can be electronically signed and stored in the database. Under no circumstances can any single form (e.g., progress notes) be maintained both ways. All copies of an electronically signed form must either be printed and placed in the chart or stored in the database so that anyone seeking one of them will only have one place to go and look for it. A facility **cannot** elect to have people choose to have the form in electronic format for some patients (or providers) and have the form printed for other patients (or providers). **A given form must be either all printed or all electronic.**

- If an electronically signed form is not going to be printed, but instead is being stored in the database, then the facility must have a mechanism for ensuring that all persons using the chart are accessing the electronic version of that form.

- The facility's disaster plan must address the recovery of any form which is being electronically signed and stored in the EMR database in the event of a system failure.

Central Office has a mechanism in place for ensuring that critical clinical information is available to all facilities in the event of a power or network failure. This information will enable facilities to treat patients should the failure last anywhere from several hours to several days.

Any questions concerning the electronic signature standard should be addressed to OMH Information Security Officer Questions concerning areas of the medical record should be addressed to OMH Chief Medical Informatics Officer. Questions concerning the Information Technology aspects of the EMR should be addressed to HelpDesk. Questions concerning EMR policy should be addressed to the EMR Business Owner.

Appendix B

FORM	PURPOSE OF FORM	In Use/Discontinued	Current Form Location	RESPONSIBLE STAFF	Population: Adult Civil Y/N	Population: C&A Y/N	Population: Forensic Y/N	TIMEFRAME OF COMPLETION - Inpatient-(IP) Civil, Forensics, STARC	TIMEFRAME OF COMPLETION - Outpatient-(OP) (MHOTRS/Clinic, ACT, MIT, Day Tx, Intensive Day Tx, CBO (Corrections Based Operations))	TIMEFRAME OF COMPLETION - Residential (SOCR, RCCA, Family Care, Respite)
Adult Rehab and Recovery Assessment (old name: Core Evaluation Inpatient Part II)	Purpose: The purpose of the Adult Rehab and Recovery Assessment is to analyze the data gathered in the core history or to identify the treatment needs related to rehabilitation service needs and provide recommendations which will form the basis of the ISP.	**In Use**	**MHARS**	Responsible Staff: The facility may designate who is responsible for completing this form.	Yes		Yes	IP Adult Civil-Initial completed within 5 days of admission, updated three months from admission date and every three months subse CNYPC CBO: not usedquently, as clinically indicated and at a minimum, annually IP Forensic: same as IP Adult Civil STARC: optional	Not Applicable	Not Applicable
AIMS (Abnormal Involuntary Movement Scale)	**Purpose**: The **AIMS** (Abnormal Involuntary Movement Scale) is a 12-item clinician-rated scale to assess the severity of tardive dyskinesia (orofacial movements, extremity, and truncal movements) in individuals taking antipsychotic (neuroleptic) medications. Additional items assess the overall severity, incapacitation, and the individual's level of awareness of the movements and distress associated with the involuntary movements. Tardive dyskinesia risk increases during the first three months of starting an antipsychotic medication. Possible risk factors: Older age, female gender, cumulative duration, higher dose of antipsychotic medication, early occurrence of drug-induced movement disorders, prior ECT treatment history, schizophrenia and related disorders, intellectual disability, history of mood disorder, alcohol or substance use disorder, dementia, and diabetes.	**In Use**	**MHARS**	**Responsible staff**: Psychiatrist / Nurse Practitioner / House Staff / Physician Assistant / Medical Specialist	Yes	Yes	Yes	Inpatient: Adult Civil, Adult Forensics, Child/Adolescent: Within 24 hours of admission and the start of an antipsychotic medication for an antipsychotic-naive individual. Then every six months or more often if clinically indicated. Notation: If the patientindividual is not on an antipsychotic medication, AIMS should be completed within 24 hours of admission.	Outpatient (OP): Adult Civil, Child/Adolescent, Adult Forensics, and ACT programs: Within 24 hours of admission and the start of an antipsychotic medication for an antipsychotic-naive individual. Then every six months or more often if clinically indicated. Notation: If the patientindividual is not on an antipsychotic medication, AIMS should be completed within 24 hours of admission.	NA
Assessment of Episodic Pain Part-A, B, and C (old name: Pain Screening/Assessment)	**Purpose**: Universal pain screening is an increasingly common practice, primarily because the Joint Commission on Accreditation of Healthcare Organizations (TJC) requires that accredited hospitals and clinics assess all patients for pain. The Assessment of Episodic Pain is intended to improve the quality of pain management by systematically identifying patients with pain in a clinical setting. Effective identification, assessment, and management of pain in hospitals and outpatient services are critical to reducing suffering, preventing functional decline, and improving people's quality of life.	**In Use**	**MHARS**	**Responsible staff**: Nursing Staff, Prescribers, Nurse Practitioner, House Staff.	Yes	Yes	Yes	IP: The Assessment of Episodic Pain Part- A and B should be completed within 24 hours of admission, annually, and as indicated for acute/observed pain onset. Chronic pain: If the Assessment of Episodic Pain Part-A is positive, the Assessment of Episodic Pain Part-B must be completed at the same time as Part-A. The Assessment of Episodic Pain Part -C must be completed within 24 hours for the Chronic pain. Acute/observed pain: If the Assessment of Episodic Pain Part-A is positive, the Assessment of Episodic Pain Part-B must be completed at the same time as Part-A. The Assessment of Episodic Pain Part -C must be completed on the same day of the acute/observed pain.	OP: At the time of admission to the outpatient services.	NA
ASSIST (Alcohol, Smoking, and Substance Involvement Screening Test)	**Purpose**: The ASSIST is a screening tool to assist with the early identification of substance use and its related health risks. The ASSIST is an eight (8) items questionnaire designed to be administered by the clinician. It is culturally neutral and useable across various cultures to screen for different substances. The ASSIST's score falls into a "lower," "moderate," or "high" risk category, which determines the most appropriate intervention for the level of use.	**In Use**	**MHARS**	**Responsible staff**: The facility may designate responsible staff to complete the ASSIST.	Yes		Yes	IP: Within 24 hours of admission. If it cannot be completed with 24 hours of admission it should be documented that an attempt was made to complete the substance use screening within 72 hours. If ASSIST is a moderate or high risk, a substance use assessment should be completed, as indicated by outcome of ASSIST.	OP: Available for screening and admission episodes. Due within 7 days of initial presentation and repeated annually, or as clinically indicated. If ASSIST is a moderate or high risk, a substance use assessment should be completed, as indicated by outcome of ASSIST.	NA
Core History (includes Core Eval Inpatient I)	Purpose: The Core History provides information of events, behaviors, reason for admission, and history to identify individual's treatment interventions while in care. The Core History information supports the anticiapted discharge needs of the individual.	**In Use**	**MHARS**	Responsible Staff: May be completed by primary clinician but must be confirmed by a Social Worker for TJC Accredited facilities in the inpatient setting.	Yes	Yes	Optional	IP-Completed within 5 days of admission, updated as clinically indicated and at a minimum, annually. IP Forensic: same as IP Adult Civil	OP-Completed within 30 days of admission, updated as clinically indicated and at a minimum, annually. OP- Act Team Units must complete within 30 days of admission, update every 6 months and annually.	NA
CRAFFT+N	Purpose: The CRAFFT+N is a health screening tool designed to identify substance use, substance-related riding/driving risk, and substance use disorder among youth ages 12-21.	**In Use**	**MHARS**	Responsible Staff: Facility designates responsible staff		Yes			OP: Available for screening and admission episodes. Due within 7 days of initial presentation and repeated annually, or as clinically indicated. 30 days of admission If CRAFFT+N is a moderate or high risk, a substance use assessment should be completed, as indicated by outcome of CRAFFT+N .	NA
Cultural Evaluation	Purpose: To increase understanding of the individual's cultural experience to inform the treatment approach.	**In Use**	**MHARS**	Responsible Staff: Social worker, primary therapist, or facility designee.	Yes	Yes	Yes	IP: Within 5 days of admission and annually if clinical indicated on Core History. The evaluation may be completed at any time during the course of treatment. *Unsure what the clinical indicators for the eval are	OP: May complete as indicated.	NA
Discharge Summary Follow up Part II (30 day post discharge follow-up)	Purpose: The Discharge Summary Follow up Part II (30-day post-discharge follow up) is completed in order to document whether or not the individual has attended their post-discharge follow up appt.'s. It is also an opportunity to review the discharge plan and address any concerns that may have arisen.	**In Use**	**MHARS**	Responsible staff: Inpatient social worker, primary therapist, or facility designee.	Yes	Yes		Within 30 days from the time of inpatient discharge. CNYPC does not complete this form. There is no post appointmetn follow up as patientindividual sare only discharged to jail, prison, or civil PC	NA	NA
Discharge Summary Part II Inpatient	Purpose: To summarize the course of treatment, upcoming appointments and referral information.	**In Use**	**MHARS**	Responsible staff: The primary clinician. *To double check with Karen Haus around whether or not it needs to be the SW.				Inpatient	N/A	N/A

Discharge summary Part 2 (Outpatient)	Purpose: To summarize the course of treatment, upcoming appointments and referral information.	**In Use**	**MHARS**	Responsible staff: Inpatient social worker, primary therapist, or facility designee.				Outpatient Clinic/MHOTRS The discharge summary must be made available to receiving service providers prior to the individual's arrival (or within two weeks of discharge, whichever comes first). Within 7 days of discharge? At the time of discharge? ACT The discharge summary is completed and transmitted to the receiving program prior to the arrival of the individual.		
Discharge Summary/Service Plan-Part I Follow up (24 Hours)	Purpose: The 24 hour Post Inpatient Discharge Warm Handoff is completed by a facility designated staff member to document warm handoff occurred with the next provider. It identifies a list of forms sent to next provider and mode of transmission. If applicable, indicates discharge information was provided to a parent/guardian, and notification was made for CPL 730.40 order. The warm handoff includes verification of discharge information received by the next provider of care.	**In Use**	**MHARS**	Responsible staff: Inpatient social worker, primary therapist, or facility designee.	Yes	Yes	Yes	24 hours from the time of inpatient discharge	NA	NA
Discharge Summary/Service Plan-Part I Follow up (48 hour post-discharge follow up)	Purpose: The 48 hour Post Inpatient Discharge Follow Up is completed to conduct a post-discharge follow up phone call to the individual (for adults) and the parent/guardian (for youth) after discharge from a State Operated Psychiatric Facility. It provides an opportunity to review the discharge plan and address any concerns that may have arisen.	**In Use**	**MHARS**	Responsible staff: Inpatient social worker, primary therapist, or facility designee.	Yes	Yes	Yes	Within 48 hours from the time of inpatient discharge. CNYPC does not complete this form. There is no post appointment follow up as patients are only discharged to jail, prison, or civil PC. IP Forensic: only if being discharged to the community CNYPC CBO: only if being discharged to the community STARC: only if being discharged to the community	NA	NA
DNR-Do Not Resuscitate		**In Use**	**On Paper**					IP: Pt w/o capacity & w/o surrogate: order every 31 days, reviewed every 7 days Pt with capacity: order every 31 days, reviewed every 7 days. Surrogate consent: order reviewed every 7 days.	NA	NA
Health Screening	Purpose: The purpose of the Health Screening questionnaire is to identify the individual's current medical problems, medications, allergies, risk factors, and family risk factors to help determine the need for follow up and ongoing health maintenance.	**In Use**	**MHARS**	Responsible Staff: Individual, family, caregiver/guardian, clinician, and/or with the assistance of facility designated staff as needed.	Yes				OP: Within 30 days of admission. and as clinically indicated.	NA
History & Physical Examination	Purpose: The purpose of the History and Physical is a comprehensive assessment by the health provider, including a physical examination is to obtain sufficient information to determine the individual's need for medical evaluation and/or treatment, develop treatment recommendations for the ISP and track the progress of the problems/diagnoses throughout the course of treatment.	**In Use**	**MHARS**	Responsible staff: Inpatient: History and Physical examination should be completed by MSO credentialled prescriber. *** Can only be done by a Med Spec or MD	Yes	Yes	Yes	IP-The History and Physical examination should be completed within 24 hours of admission, annually, and updated as clinically indicated or required by accepting agency.	OP: NA	NA
Individual Calming, Wellness & Resilience Plan (ICWRP)	Purpose: ICWRP and wellness plans are completed to help prevent or minimize the likelihood of a crisis by identifying strategies that support youth's participation in treatment. Wellness plans are completed collaboratively with an individual to identify early warning signs, things to avoid, and tools to use during crisis.	**In Use**	**On Paper**	Responsible Staff: The facility may designate responsible staff.		Yes		IP Child/Adolescent only: Part 1 within 24 hours of admission, Part II within 7 days of admission. Updated throughout hospitalization after each restrictive intervention.	NA	NA
Nursing Assessment	Purpose: The purpose of the Nursing Assessment is to gather, evaluate the information need to formulate nursing diagnoses, prioritize needs, and develop recommendations for nursing interventions for the Treatment Plan/ISP.	**In Use**	**MHARS**	Responsible staff: Nursing Assessment Parts I and II are completed by the registered nurse. Notation: At the direction of the registered nurse, other nursing personnel may assist to gather information.	Yes	Yes	Yes	IP- Nursing Assessment Part I-within 8 hours of admission and Nursing Assessment Part II-within 24 hours of admission, updated annually, and as clinically indicated.		NA
Patient Registration (old name 725-Admission/Screening/Trial Placement)	Purpose: The Admission/Screening/Trial Placement form (725) provides the hospital with the information, including demographic, emergency contact, and insurance information needed to process the registration.	**In Use**	**MHARS**	Responsible staff: The facility can designate individuals to complete the 725-Admission/Screening/Trial Placement form, including clerical staff, the admissions coordinator, RN, PSC, or primary therapist.	Yes	Yes	Yes	Completed at the time of admission , screening and can be updated during the episode of care.	Completed at the time of admission or, screening and can be updated during the episode of care.	Completed at the time of admission and can be updated during the episode of care.
Positive Behavior Supports Assessment	Purpose: The purpose of the Positive Behavior Support Assessment is to gather baseline data on the intensity, frequency, and functions of goal- interfering behaviors to inform the development of a Positive Behavior Support Plan	**In Use**	**MHARS**	Responsible Staff: Psychologist or other clinician competent in behavioral assessments and intervention planning	Yes	Yes	Yes	Referral-based, should be done in a timely manner following a referral to aid treatment planning and interventions	Referral-based, should be done in a timely manner following a referral to aid treatment planning and intervention	Referral-based, should be done in a timely manner following a referral to aid treatment planning and intervention
Positive Behavior Support Plan	The purpose of the Positive Behavior Support Plan is the development of a strategy to aid the learning and use of new skills to replace goal-interfering behaviors in support of goal attainment.	**In Use**	**MHARS**	Responsible Staff: Psychologist or other clinician competent in behavioral assessments and intervention planning	Yes	Yes	Yes	Referral-based, should be done in a timely manner following a referral to aid treatment planning and interventions	Referral-based, should be done in a timely manner following a referral to aid treatment planning and interventions	Referral-based, should be done in a timely manner following a referral to aid treatment planning and interventions

Psychiatric Evaluation-Screening (old name Screening Admission Psych Eval Part I)	Purpose: The psychiatric evaluation – screening is not a required document. It is used when the prescriber is not able to complete the psychiatric evaluation-Comprehensive at the time of admission.	**In Use**	**MHARS**	Responsible staff: Psychiatric Prescribers Must be completed by a prescriber (physician/NPP/PA) and co-signed by an attending physician if completed by a resident physician without a full independent NY State medical license.	Yes	Yes	Yes	IP- The Psychiatric Evaluation- Screening is required to be completed at the time of admission ONLY if the Psychiatric Evaluation – Comprehensive cannot be completed at the time of admission. If the Psychiatric Evaluation- Screening is completed at the time of admission, the Psychiatric Evaluation-Comprehensive must be completed within 60 hours of the admission.	OP: The Psychiatric Evaluation- Screening is required at the time of admission ONLY if the Psychiatric Evaluation – Comprehensive cannot be completed at the time of admission. If the Psychiatric Evaluation- Screening is completed at the time of admission, the Psychiatric Evaluation- Comprehensive must be completed within 30 days of the admission.	NA
Psychiatric Evaluation Comprehensive (Old name: Psychiatric Evaluation/Assessment)	Purpose: The CMS requires that accredited hospitals and clinics complete Psychiatric Evaluations for all patients admitted to inpatient and outpatient settings that meet regulatory requirements. The Psychiatric Evaluation - Comprehensive is completed for clinical and therapeutic purposes to diagnose, formulate the individual's problems, and plan the individual's care and treatment. The Psychiatric Evaluation may be done in a hospital (or inpatient) setting, outpatient, or community setting (as a home-based assessment).	**In Use**	**MHARS**	Responsible Staff: Must be completed by a prescriber (physician/NPP/PA). For inpatient settings, must be signed or co-signed by an attending physician or a resident physician holding a full independent NY State medical license. For outpatient settings, must be signed or co-signed by an attending physician if completed by a resident physician without a full independent NY State medical license.	Yes	Yes	Yes	IP- Psychiatric Evaluation- Comprehensive Sshould be preferably completed at the time of admission but must be completed or within 60 hours of admission if the Psychiatric Evaluation-Screening is completed at the time of admission. The Psychiatric Evaluation- Comprehensive and must be completed updated at a minimum - annually, or more frequent as clinically indicated.	OP- Psychiatric Evaluation- Comprehensive Sshould be preferably completed at the time of admission but must be completed or within 30 days of admission if the Psychiatric Evaluation-Screening is completed at the time of admission. The Psychiatric Evaluation-Comprehensive and must be completed updated at a minimum- annually, or more frequent as clinically indicated.	NA
Psychological Evaluation	Purpose: The purpose of the Psychological Evaluation is to document a psychological assessment or consultation including record review, behavioral observations, and testing data as appropriate, and provide recommendations.	**In Use**	**MHARS**	Responsible Staff: Psychology Staff or designee	Yes	Yes	Yes	IP: Based on Referral, as ordered for services indicated on documentation.	OP: Based on Referral, as ordered for services indicated on documentation..	NA
Recovery Map	Purpose: The Recovery Map is a therapeutic tool developed by the Beck Institute as a key component of Recovery-oriented Cognitive Therapy (CT-R). The purpose of the Recovery Map is to guide treatment through strategic engagement, planning, and development of a clinical, strengths-based, personalized path toward the individual's aspirations. Its purpose is to guide treatment planning; thus, the results should inform treatment planning. Recovery Map Aspirations should inform treatment Goals and Objectives. Strategies of engagement should be incorporated into methods to attain intermediary objectives striving toward long-term goals.	**In Use**	**On Paper**	Responsible Staff: Recovery-oriented Cognitive Therapy (CT-R) is a team-based approach to therapeutic interventions. The completion of the Recovery Map generally is a done with all members of the individual's care team, led by a psychologist, social worker, or other service provider skilled in CT-R.	Yes	Yes	Optional	IP The Recovery Map should be completed as indicated.	OP: The Recovery Map should be completed as indicated.	Res: The Recovery Map should be completed as indicated.
Substance/Alcohol Use Assessment (old name Alcohol and Drug Use/Abuse Evaluation)	Purpose: The purpose of the Substance/Alcohol Use Assessment is to determine the extent of its use, co-occurring disorder diagnoses, functional impairments, and to assist in developing a treatment plan / individual service plan. The Substance Use Assessment also meets the TJC requirements.	**In Use**	**MHARS**	Responsible Staff: The facility may designate responsible staff to complete the Substance Use Assessment.	Yes	Yes	Yes	IP: The Substance Use Assessment should be completed within seven (7) days of admission and prior to developing a comprehensive treatment plan / individual services plan if it is indicated based on the substance use screening tool or as per the clinician's clinical decision. Notation: The Substance Use Assessment may be completed or updated at any time during the course of treatment, however, because the assessment can determine areas to target in treatment, it is recommended that the Substance Use Assessment should be completed prior to the review of the treatment / individual service plan.	OP Clinic: The Substance Use Assessment should be completed within 30 days of presentation admission and prior to developing a comprehensive treatment plan / individual services plan if it is indicated based on the substance use screening tool or as per the clinician's clinical decision. OP ACT: The Substance Use Assessment should be completed within 60 days of presentation admission and prior to developing a comprehensive treatment plan/individual services plan if it is indicated based on the substance use screening tool or as per the clinician's clinical decision. Notation: The Substance Use Assessment may be completed or updated at any time during the course of treatment, however, because the assessment can determine areas to target in treatment, it is recommended that the Substance Use Assessment should be completed prior to the review of the treatment / individual service plan.	NA
Suicide Safer Care Protocol (SSCP)	Purpose: The purpose of the suicide risk assessment is to identify risk and protective factors that inform the individual's treatment and safety management.	**In Use**	**MHARS**	Responsible Staff: The facility may designate responsible clinical staff. to complete the SSCP.	Yes	Yes	Yes	IP: Initial within 24 hours of admission (or documentation within 5 calendar days if patientindividual u's nacuity allows cooperative) , 7 (seven) days prior to discharge, and as clinically indicated.	OP: At first visit or no later than 5 days from first visit. Frequency of follow up assessments depend on the pathway the person is assigned.	NA
UCLA PTSD Reaction Index for DSM-5	Purpose- The UCLA PTSD Reaction Index for DSM-5 screens for exposure to traumatic events and assesses PTSD symptoms in school age children and adolescents. Notation: Results may be incorporated into the Core History, Crisis/Calming Plan or a Progress Note. Results and treatment recommendation location should be communicated to rest of clinical team.	**In Use**	**MHARS**	Responsible Staff: May be completed by prescriber, primary clinician, social worker, or psychologist.		Yes		IP-Completed within 5 days of admission, updated as clinically indicated.	OP-Completed within 30 days of admission, updated as clinically indicated.	NA
Violence Risk Screening	Purpose: The purpose of violence risk screening is to identify the need for further violence assessment.	**In Use**	**MHARS**		Yes			IP: Within 24 hours of admission, annually and as indicated.	OP: Within 30 days of the admission, annually, and as clinically indicated.	NA
Violence Risk Assessment (For example the HCR-20)	Purpose: A longer term full assessment to identify someone's risk for violence. No specific violence risk assessment tool is required. The HCR-20 is available for all OMH State Operated providers.	**In Use**		Responsible staff: The violence risk assessment should be the collaborative responsibility of the full interdisciplinary team, and all providers with clinical interaction with the individual should have the opportunity to contribute to the assessment.	Yes			IP: The timeline for completion of a violence risk assessment should be determined by each facility. The violence risk assessment should be completed in a timely manner to ensure recommendations are incorporated in the ISP and implemented to address modifiable risk behaviors.	OP: The timeline for completion of a violence risk assessment should be determined by each facility. The violence risk assessment should be completed in a timely manner to ensure recommendations are incorporated in the ISP and implemented to address modifiable risk behaviors.	N/A

BROSET Violence Checklist	Purpose: A monitoring tool for violence risk. The Broset Violence Checklist (BVC) is an acute risk assessment tool used to identify and address shift to shift changes in symptoms and behavior that may indicate an elevated imminent risk of violence (within a 24-hour period), It is shared with the treatment team for awareness and appropriate immediate intervention and/or treatment plan modifications. More information about the BROSET can be found on the OMH HUB.	**In Use**		Responsible staff: Nursing and/or therapy aide staff members				IP: Completed per shift until there is no longer a clinical need. Restarted if there is a clinical incident necessitating ongoing monitoring.	OP: N/A	Res.: N/A
Violence Risk Screening Questionnaire– Forensic Version	Purpose: Violence risk screening is a core competency requirement for clinicians. The purpose of violence risk screening is to identify the need for further violence assessment.	**In Use**	**MHARS**					IP Forensic: same as IP Adult Civil		NA
Comprehensive Suicide Risk Assessment (CSRA)	Purpose: To assess suicide risk	**In Use**						STARC – within one day of admission; when PSS-3M indicates CSRA, new risk/protective factor arises, discretion of provider.		NA
Patient Safety Screener – 3 (PSS)	Purpose: To assess suicide risk	**In Use**						STARC – trigger/warning sign, at ISP, provider discretion		
Nursing Discharge Summar	Purpose: To summarize necessary follow up for ensuring continuity of care and a safe return to the community, documenting appointments, names of providers and the details of the follow up plan specific to nursing.	**In Use**	**MHARS**	Responsible Staff: Nursing	Yes	Yes	Yes		NA	NA
Academic Education Assessment	Purpose: To gather relevant information about student performance and progress to align learning goals and standards. Academic testing should be completed based on need to improve learning outcomes or identify educational services.	**In Use**	**MHARS**	Responsible Party: Educator	Yes	Yes	Yes	IP – C&A completed 10 days from admission IP- Adult and forensic 18 – 21, 10 days for individual enrolled in school IP Adult and forensic per referral as requested	N/A	N/A
HIV Pre Counseling	Purpose: To inform the patient prior to consent for HIV testing how the HIV virus spreads, treatments available, safe practices, testing is voluntary, no discrimination, and all results confidential	**In Use**	**MHARS**	Responsible Party: Admitting prescriber				Upon Admission and after any exposure situation	Not applicable	Not applicable
HIV Post Counseling	Purpose: To review the results of the HIV testing confidentially and offer counseling, strategies and resources, requirements of reporting, importance of follow up for medical care, good health practices and reducing transmission	**In Use**	**MHARS**	Responsible Party: Admitting prescriber				Within a week of receiving the test results	Not applicable	Not applicable
Allergies	To determine allergies to medications and other substances to avoid adverse reactions	**In Use**	**MHARS**	Responsible Party: Admitting prescriber				Upon Admission	Upon Admission	Not applicable
Viral Contagion	Purpose: To determine if an individual is experiencing symptoms of a viral contagion upon contact with the patient. Provide guidance for next steps to be followed when specific symptoms and/or criteria are identified for diagnosis.	**In Use**	**MHARS**	Responsible Party: Admitting prescriber				Upon Admission	Not applicable	Not applicable