**Section 205.610 Clinical Records** **and Reports**

a) The ASTC shall maintain accurate and complete clinical records for each patient, and all entries in the clinical record shall be made at the time the surgical procedure is performed and when care, treatment, medications, or other medical services are given. The record shall include, but not be limited to, the following:

1) Patient identification;

2) Admitting information, including any patient medical history and physical examination findings as applicable, diagnosis or need for medical services, and all consultation reports;

3) Pre-counseling notes;

4) Signed informed consent;

5) Confirmation of a pregnancy (when an abortion is performed);

6) Signed physician orders;

7) Laboratory test reports, pathologist's report of tissue or other specimens including foreign bodies, and physician's, podiatrist's, dentist's or radiologist's report of imaging studies;

8) An anesthesia record;

9) The operative record, describing techniques, findings and tissues or other items removed or altered, shall be written or dictated immediately following surgery and signed by the surgeon. The operative record shall include, but not be limited to:

A) The name and ASTC identification number of the patient;

B) The date and time of the surgery;

C) The names of the surgeon or surgeons and assistants or other practitioners who performed surgical tasks, including practitioners who performed those tasks under supervision;

D) The pre-operative and post-operative diagnosis;

E) The name of the specific surgical procedure or procedures performed;

F) The type of anesthesia administered;

G) Complications, if any;

H) A description of techniques, findings, and tissues or other items (such as foreign bodies) removed or altered;

I) A description of the specific significant surgical tasks that were conducted by practitioners other than the primary surgeon or practitioner, including, but not limited to, opening and closing, harvesting grafts, dissecting tissue, removing tissue, implanting devices, altering tissues, or monitoring; and

J) Prosthetic devices, grafts, tissues, transplants or devices, if any, that were implanted in, or removed from, the patient;

10) Medication administration and medical treatments that were performed;

11) Recovery room progress notes;

12) Physician and nurse progress notes;

13) The patient's condition at time of discharge;

14) Patient instructions; and

15) Post-counseling notes.

b) The ASTC shall comply with the Pregnancy Termination Report Code.

c) Record Retention

1) The ASTC shall preserve and retain a patient's clinical records, in a format established by the facility's written policy, for not less than 10 years after the date of service. If the patient was a minor on the date the record was produced, the records shall be retained until the patient is 23 years old, or at least 10 years after the date the record was produced, whichever is longer.

2) If the ASTC has been notified in writing by an attorney of pending litigation involving a patient's clinical record before the expiration of that record's retention period, the ASTC shall retain the record until the ASTC receives documentation that the litigation involving the record has been concluded, or for 10 years after the date of service, whichever occurs later. If the litigation involves a patient who was a minor when the record was produced, the ASTC shall retain the record until the patient is 23 years old, or at least 10 years after the date the record was produced, whichever is longer.

3) The ASTC shall retain, for as long as it remains in business, a list of organizational-approved procedures, pursuant to Sections 205.120(b)(10), 205.125(b)(9), and 205.130(a).

4) The ASTC shall retain its sterilizer logs for a minimum of three years.

5) The ASTC shall retain its pharmacy narcotics receipts and inventory for a minimum of three years.

d) An ASTC found in violation of this Section shall be penalized pursuant to Subpart H.

(Source: Amended at 46 Ill. Reg. 14215, effective July 28, 2022)