**Section 330.1720 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) Marital Status, and the name of spouse (if there is one),

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

4) Date of current admission to the facility,

5) State or country of birth,

6) Home address,

7) Religious affiliation (if any),

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

9) Name and telephone number of the resident's personal physician,

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

11) Race and origin,

12) Most recent occupation,

13) Whether the resident or the resident's spouse is a veteran,

14) Father's name and mother's maiden name,

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

16) The diagnosis applicable at the time of admission.

b) 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) 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 restoration potential. 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 treatments, diet, activities and special procedures or orders required for the safety and well-being of the resident. The physician's order sheet shall also include a record of the medications prescribed for the resident by the physician, and a statement that the resident is capable of self-administering these medications.

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

A) 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 and work programs shall be recorded as they are noted. If no significant observations or developments are noted for three months, an entry shall be made in the record of that fact.

4) 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.

5) The results of the physical examination conducted pursuant to Section 330.1110(d) of this Part.

6) 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.

(Source: Amended at 13 Ill. Reg. 6562, effective April 17, 1989)