Practice Standard: Clinical Record Keeping

Applies to Traditional Chinese Medicine Professionals & Acupuncturists

The College of Complementary Health Professionals of BC was created on June 28, 2024 through the amalgamation of four health regulatory colleges:

- College of Chiropractors of BC
- College of Massage Therapists of BC
- College of Naturopathic Physicians of BC
- College of Traditional Chinese Medicine Practitioners and Acupuncturists of BC

All current requirements for standards of clinical and ethical practice issued by the four colleges remain in place upon amalgamation.

This document was created by the College of Traditional Chinese Medicine Practitioners and Acupuncturists of BC and will be updated to reflect the amalgamation.

CLINICAL RECORD KEEPING

September 12, 2015
Amended March 2, 2019

It is the responsibility of each registrant to be familiar with the Bylaws, including Schedule A Code of Ethics and Schedule B Standards of Practice. Registrants are also expected to be familiar with the CTCMA Jurisprudence Handbook and Safety Program Handbook.
This Practice Standard is to be read in conjunction with, and not a substitute for, these documents.

Intent

This practice standard is intended to support the Standards of Practice and is based on section 3(c) v of the Jurisprudence Handbook and section 3.7 Risk Management: Patient and their Records of the Safety Program Handbook.

It describes the standards that the College expects of its registrants in record keeping to ensure registrants meet the Standards of Practice and protect public safety. It sets out the essential records that registrants of the College are required to keep in the care of their patients and in the operation of their practices.

The Registrar, staff, the Quality Assurance Committee, the Inquiry Committee and the Discipline Committee will use this practice standard in the interpretation and application of the *Health Professions Act* (HPA), RSBC 1996.

In the case of any inconsistency between this practice standard and the underlying legislation, the legislation takes priority.

Background

To fulfill their professional obligations, registrants of the College must maintain accurate, legible and up-to-date records for each of their patients in order to provide proper care and treatment. The first part of this practice standard describes the required records that practitioners must keep.

Patients have the right to expect that their personal information will remain confidential and that they can expect a standard of care that a reasonably prudent professional practitioner would provide.

The second part of this practice standard describes how records kept by registrants must be maintained. (Part VI of the College bylaws)

Acknowledgement

The College gratefully acknowledges permission from the College of Traditional Chinese Medicine Practitioners and Acupuncturists of Ontario to adapt their practice policy on record keeping.

Types of Record to Maintain

1. Daily Appointment Log

A written or electronic daily appointment log must contain:

- Date
- The surname, first name and/or initials of each patient
- The time and/or duration of appointment of each patient

2. Patient File

It is mandatory that registrants maintain a confidential file for each patient that contains:

2.1. Patient Health Summary (Sample Form A)

This summary acts as a cover page of a patient's health record to give a snapshot of the overall history of a patient. It lists essential information of the patient to allow a quick reference on the patient's overall health and progress to-date.

A Patient Health Summary must exist for each patient. Registrants may use Sample Form A to fulfill this requirement, or they may create and use their own form. A Patient Health Summary must contain the following information:

- Patient identification (name, address, phone number)
- Personal and family data (Date of Birth, Gender, Occupation, Marital Status)
- Family contact Information
- Emergency contact information
- Family Doctor (name, address, phone number)
- Past medical history
- Risk factors
- Allergies/drug reactions
- Ongoing health conditions
- Long-term treatment
- Date of last update of the Patient Health Summary

2.2. Patient Health Record (Sample Form B)

The Patient Health Record provides the registrants with a clear understanding of the patient's current and past health conditions, identified health concerns, the courses of diagnosis and treatment being followed. Accurate, clear and concise documentation facilitates follow-up treatment and prevents error.

Registrants may use Sample Form B, or create their own Patient Health Record, as long as the following is included:

a) Patient History

- Personal health and medical history (ongoing problems, past illnesses, operations, allergies, drug reactions, prescription medications, herbal supplements, vitamins, over the counter remedies etc.)
- Family health history
- Referring professional's diagnosis

b) Initial Assessment/Diagnosis and Treatment
- Presenting condition/chief complaint
- Signs and symptoms
- TCM diagnosis and treatment (identified TCM disease, TCM differentiation of syndromes)
- Treatment principles and strategies
- Treatment plan (modalities; acupuncture, herbal, dietary, manual therapies), frequency and duration.
- Advice given to patients

c) Follow-Up Treatment
- Date of visit
- Progress inquiry
- TCM differential diagnosis
- Treatment plan modification
- Contraindications
- Herbal medicine prescription
- Acupuncture prescription
- Adjunct modalities/treatment or procedures used and specifics
- Patient's reaction to treatment
- Document patient refusal to follow recommendation

d) Information on other health care provider treatment that the patient is or has been receiving services
- Referring healthcare provider (Regulated Health Professional)
- Name, address and phone number
- Other relevant care provider (e.g. personal support workers)
- Name, address and phone number
- Communications to and from other healthcare providers

e) Tests/Reports
- Signed reports compiled/produced by the treating registrant
- Reports requested and received from another healthcare professional
- Initial and date reports after review

f) Patient Consent to Treatment (Sample Form C)

A patient has the right to receive sufficient information in order to make an informed decision on whether to accept treatment. Registrants must ensure that their patients know, understand and consent to their assessments or treatments before taking any action.

It is important that consent be informed by means of a meaningful dialogue between the registrant and the patient.

To ensure informed consent, a registrant must explain each part of the Patient Consent to Treatment Form to the patient prior to patient signing on the form. It is not enough to simply allow the patient to read and sign the Consent to Treatment form. Each of the sections contained within the form must be reviewed and explained by the registrant to the patient.

Registrants may use Sample Form C or create their own Patient Consent to Treatment Form, as long as it contains the following information:

- A voluntary acknowledgement of risk by the patient, with the option to withdraw their consent and halt participation at any time
- A description and explanation of the services, techniques or procedures that may be used on the patient
- Herbal (prescribed formulas documented)
- The possible risks, side effects or consequences associated with any potential treatments
- A section asking patients to divulge any major past or current health issues to the practitioner
- A section asking patients to divulge if they are, or believe that they may be carrying any infectious agents
- A section outlining that there are no guarantees for the results of TCM/Acupuncture treatments
- A section detailing the fees related to the cost of assessments or treatments
- Evidence of patients refusal to consent treatment (as appropriate)
- An overall acknowledgement of informed consent and agreement of the entire form authorizing the practitioner to begin treating the patient
- Patient's signature and date
- Practitioners signature and date

g) Consent to Collect or Release Information (Sample Form D)
Registrants must always obtain the consent of patients when collecting, using or disclosing personal health information of their patients, unless permitted by the *Personal Information Protection Act* (PIPA)

Written expressed consent must be documented, signed and dated by the patient.

Registrants may use Sample Form D or create their own Consent to Collect or Release Information Form, as long as it contains the following information:

- A space for the patient or their appointed representative to print his or her name
- An acknowledgement by the patient for the practitioner/clinic to collect or release their information to other health care practitioners, support workers, emergency personnel or any other relevant organizations.
- A description of how the patient's information will be used
- A description concerning the patient's access to information
- A description of any applicable fees for reproduction or translation of records
- An overall acknowledgement that the patient understands the form and his/her ability to withdraw consent at any time
- Patient's signature and date
- Witness signature and date

2.3. Patient Billing Records (Sample Form E)

Patient billing records are records related to billing or payment for services and/or goods provided by the registrant to the patient.

Registrants may use Sample Form E, or create their own Patient Billing Form, as long as it contains the following:

- Date of service
- Name of patient
- Professional fees charged
- Itemized services offered
- List of any herbal prescriptions, natural health products, or any other type of product billed to the patient
- Itemized list of equipment, if prescribed
- Total payment charged
- Name and registration number of the registrant performing the service/providing the product(s)

The patient billing record can be used for a practitioner's own records or be given to patients or any other legitimate third parties (for example, insurance companies paying on behalf of a patient).

2.4. Patient Record Maintenance and Management

General Principles

Entry must be made to the patient record at the time of consultation or immediately after. All entries must be dated. The treating registrant cannot delegate responsibility for the accuracy of the patient's health information to another person.

In cases where students are entering information into a patient's record, information entered must be signed off on by their supervising practitioner. The supervisor is responsible for ensuring that the information entered is complete and accurate.

Information on records cannot be deleted or removed. Written communication relating to the care of the patient sent to or received from the patient must be kept in the patient file. Records may be handwritten, typed or in electronic format. If handwritten, the writing must be clear and legible.

Records, documents, reports must include:

- Date
- Reference to identify the patient
- Identity of the person(s) who performed the diagnosis/ treatment
- Identity of the person who made the entry to the record
- legend of abbreviations/signs, if used; and
- be readily understandable by any third party, especially another registrant of the College or another healthcare provider

Material in patient records must be organized and arranged in a manner for easy and prompt retrieval and managed to ensure security and confidentiality.

Making Changes to Patient Health Records

Records, documents, reports and information in the patient file cannot be deleted or removed. To make change to a patient record, the treating registrant or the responsible staff must indicate clearly what the change is and who made the change.

Changes cannot be erased or whited-out. Instead, a single line should be drawn through the entry that needs to be changed, or a “strike-out” font should be used if done electronically. Changes must be initialed by the person who makes the change. If the change is made electronically, the name of the individual making the change must be typed next to the change in the record.

Transmission of Patient Information and Records

When a request is made to transmit patient information, written consent must be expressly given by the patient or an authorized representative of the patient, with some exceptions (e.g. The patient is incapacitated). Only then can the information be sent. The costs of sending patient information will be placed upon the patient.

Patient Access to Records

Under the *Personal Information Protection Act* (PIPA), patients have a right to access his or her own personal information records. The treating registrant has an obligation to provide this information and a copy at the patient’s request unless granting access would likely result in a risk of serious harm to the patient’s treatment or recovery, or a risk of serious bodily harm to the patient or another person – in these cases, practitioners shall notify the patient of their right to complain to the Information and Privacy Commissioner.

A patient must sign a consent form, (see 2.2 (g) above) to request release of his/her file. In certain emergency situations, these requirements may be waived.

Generally speaking, consent should be obtained before sharing personal health information with members of a person’s family. However, personal information may be disclosed for the purposes of contacting family members, friends, or other persons who may be potential substitute decision-makers, if the individual is injured, incapacitated, or ill and cannot provide consent.

A registrant may disclose a person’s personal information if the registrant believes on reasonable grounds that the disclosure is necessary to eliminate or reduce a significant risk of serious bodily harm to the person or anyone else.

Providing Records

According to Section 4.4 of Schedule B (Standards of Practice for Registrants) in the College bylaws, registrants must explain their services to patients. If reproduction or translation fees will be charged, the registrants must notify the patients prior to commencement of treatment.

2.5. Equipment, Supplies and Inventory Records

Equipment and Supplies (Sample Form F - Equipment and Supply Record)
Equipment used (including devices such as heat lamps, CPR equipment, scales and slicers) must be maintained according to the standards listed by their manufacturer or supplier. Relevant information should be maintained in a log book. Additionally, registrants must detail, maintain and keep an inventory of:

- Every instrument or equipment used for service to patients
- Sterilization of equipment if used (such as a cupping instrument and/or other equipment where blood is involved)
- Other equipment service records as necessary

Inventory of Herbs (Sample Form G - TCM Herbal Inventory Record)
The College expects registrants to take great care in keeping inventory of herbs and controlling their purchases, supply and dispensing. Due to the potential risks to the public caused by contamination, expiry and toxicity of herbs, careful records of inventory must be kept.

Registrants prescribing herbs must keep detailed inventory of herbs that includes the:

- Identity and contact information of the supplier from whom the herbs are purchased
- Identity of the herbs in Chinese, pinyin, and either botanical names or Latinate medicinal names
- Only use herbs before their expiry time or date
- Ensure that herbal prescriptions (TCM) are legible and contain the necessary information of the prescription (TCM) to be accessibly and safely dispensed, used and tracked
- Storage location (toxic and/or poisonous herbs to be separately stored to prevent unauthorized access)
- A herbal prescription log or patient records containing the dosage of herbs, the name of the patient, and the date dispensed
- Date purchased

Management of Records

1. Legibility of Records

Records can be handwritten, typed, voice-dictated and transcribed, or electronically kept in computers, as long as the manner of record keeping contains the necessary information prescribed in this practice standard.

For MSP billing purposes, clinical records must be maintained in English at all times.

2. Security and Storage

The confidentiality and security of records must be taken seriously. Records must be either hand kept or electronically stored.

Records must be secure from loss, tampering, interference or unauthorized access. If paper records are kept, they must be kept in a secure area, and precautions must be made to ensure the safety of the files. If electronic records are kept, back-up files and restore protocols and process must be place.

3. Record Retention and Destructions

According to s. 83(2) of the College bylaws, patient files must be kept at least for 10 years following the last interaction with the patient. If the patient is a minor, then the patient file must be kept for 10 years following the patient's nineteenth birthday.

Destruction of records must be done in a managed and confidential way.

In terms of other files that relate to the practice, they should be kept for a period of 10 years.

4. Closing Practice/Leaving/Resignation

A registrant must follow the stipulations set out in the *Personal Information Protection Act* as well as in the College bylaws.

If the registrant intends to close his or her practice, he/she must take reasonable steps to give appropriate notice of the intended closure to each patient for whom the registrant has primary responsibility to:

i. ensure that each patient's records are transferred to the registrant's successor or to another registrant, if the patient so requests; or
ii. ensure that each patient's records are retained or disposed in a secure manner

Registrants who intend to close their practice, resign or leave an existing practice must provide his/her patients with notification of practice closure or restrictions as soon as possible after it becomes apparent that he/she will be leaving or restricting practice, in order to allow patients an opportunity to find another practitioner. They must also assist with the transfer of patient care to another provider. This includes copying the file (at the patients cost) and transferring patient files to another practitioner or simply giving a patient a copy of their file.

Acceptable methods of notification are:

1) In person, at a scheduled appointment;
2) Letter to the patient; and/or
3) Telephone call to the patient.

The registrant may also wish to use include the following supplementary methods of notification:

- Printed notice, posted in the office in a place that is accessible even when the office is closed;
- Newspaper advertisement; and/or
- Recorded message on the office answering machine

Note: If the registrant has died, his or her estate may elect to store the records and respond individually to client requests for information or it may choose to transfer the records to another practitioner who will act as a custodian.

Other Resources

- *Limitation Act* of British Columbia
  http://www.bclaws.ca/EPLibraries/bclaws_new/document/ID/freeside/00_12013_01
- *Personal Information Protection Act (PIPA)*of British Columbia
  http://www.bclaws.ca/EPLibraries/bclaws_new/document/ID/freeside/00_03063_01
- *Freedom of Information and Protection of Privacy Act (FOIPPA)* of British Columbia
  http://www.bclaws.ca/EPLibraries/bclaws_new/document/ID/freeside/96165_00
- *Medical and Health Care Services Regulation*
  http://www.bclaws.ca/civix/document/id/complete/statreg/426_97
- *Personal Information Protection and Electronic Documents Act* of Canada
  http://laws-lois.justice.gc.ca/eng/acts/P-8.6/index.html
- *Privacy Act* of Canada
  http://laws-lois.justice.gc.ca/eng/acts/P-21/FullText.html
- *Access to Information Act* of Canada
  http://laws-lois.justice.gc.ca/eng/acts/A-1/FullText.htm

Patient Health Summary (Sample form A)

Clinic Name/Practitioner Name/Registration #

Clinic Address and Phone Number

Patient Information				
Last name:		First Name:	Middle Name:	
Birth Name/Other Previous Names:			Gender: F / M / Other	
Home Address:			Date of Birth: (DD/MM/YY)	
City:	Province:	Postal Code:	Marital Status:	
Phone:		Mobile:	Occupation:	
Fax:		Email:		
Family Contact Information				
First name:			Last name:	
Relationship to Patient:		Phone Number:	Mobile Number:	
Emergency Contact information (If different from above)				
First name:			Last Name:	
Relationship to Patient		Phone Number:	Mobile Number:	
Family Doctor Contact Information				
Family Doctor Name:				
Address:				Additional Notes:
City:	Province:	Postal Code:		
Phone:	Fax:	Email:		

Past Medical History

- ☐ Mumps ☐ Herpes ☐ Hepatitis ☐ HIV+ ☐ Osteoporosis ☐ Tumor ☐ Measles
- ☐ High Blood Pressure (Hypertension) ☐ Low Blood Pressure (Hypotension) ☐ Stroke
- ☐ Fracture ☐ Arthritis ☐ Gout ☐ Diabetes ☐ Tuberculosis ☐ High Cholesterol
- ☐ Muscle Sprain ☐ Cancer
- ☐ Other:

Risk Factors

Allergies/Drug Reactions

- ☐ Penicillin ☐ Peanut ☐ Dust ☐ Pollen ☐ Dairy ☐ Gluten ☐ Wheat ☐ Chocolate ☐ Caffeine
- ☐ Other:

Ongoing Health Conditions

- [ ] Headache
- [ ] Fatigue
- [ ] Plantar Fasciitis
- [ ] Tingling in Legs
- [ ] High Blood Pressure
- [ ] Pinched Nerves in Back or Neck
- [ ] Other:
- [ ] Neck Pain
- [ ] Jaw Pain
- [ ] Bowel Problem
- [ ] Tingling in Arms
- [ ] Lower Back Pain
- [ ] Asthma
- [ ] Depression
- [ ] Dizziness
- [ ] Knee or Hip Pain
- [ ] Slipped Disc
- [ ] Mid Back Pain
- [ ] Arthritis
- [ ] Memory Loss
- [ ] Poor Posture
- [ ] Carpal Tunnel
- [ ] Menstrual Problem
- [ ] Stomach Problem
- [ ] Heart Palpitation
- [ ] Allergies

Long Term Treatment

Date of Last Update:						Signature:

Patient Health Record (Sample Form B)
Clinic Name/Practitioner Name/Registration #
Clinic Address and Clinic Phone Number

PATIENT HEALTH HISTORY

Personal Health and Medical history
(Ongoing problems, past illnesses, operations, allergies, drug reactions, prescription medications, herbal supplements, vitamins, over the counter remedies)

Family Health History

☐ Asthma ☐ Diabetes ☐ Heart Disease ☐ High Blood Pressure ☐ Thyroid Problems ☐ Multiple Sclerosis
☐ Stroke
☐ Others:

Referral Diagnosis

Practitioner:	Date:	Signature:

INITIAL ASSESSMENT

Presenting Symptom/Chief Complaint

Main Signs and Symptoms

Other Signs and Symptoms

TCM Diagnosis and Treatment (identified TCM disease, TCM differentiation of syndromes)

Treatment Principles and Strategies

Treatment Plan (Modalities; acupuncture, herbal, dietary, manual therapies), frequency and duration

Any Other Advice Given to Patients

Practitioner:	Date:	Signature:

FOLLOW-UP TREATMENT

Date of Last Visit :	Date of Follow-Up Treatment:

Progress Inquiry

TCM Differential Diagnosis (not required for each visit)

Treatment Plan Modification

Contraindications

Herbal Medicine Prescription	Acupuncture Prescription

Adjunct Modalities/Treatment or Procedures Used

Patient Reactions

Practitioner:	Date:	Signature:

Referring Health Care Provider			
Referring Health Care Provider:			
Address:			**Additional Notes:**
City:	**Province:**	**Postal Code:**	
Phone:	**Fax:**	**Email:**	
Other Relevant Care Provider			
Name of Care Provider:			
Address:			**Additional Notes:**
City:	**Province:**	**Postal Code:**	
Phone:	**Fax:**	**Email:**	

Attach any Tests/Reports below:

Patient Informed Consent to Treatment (Sample Form C)
Clinic Name/Practitioner Name/Registration # Clinic Address
Clinic Phone Number

I, or the person listed below, have discussed with my traditional Chinese medicine practitioner or acupuncturist the specifics of my assessment or treatment and understand the nature, risks and reasons for this procedure. I voluntarily consent to Traditional Chinese Medicine/Acupuncture and understand that I may withdraw my consent and halt my participation at any time.

1. I understand that some of the techniques used under the scope of Traditional Chinese Medicine include the use of sterile, single-use needles to penetrate the skin. Additional treatment methods can include, but are not limited to: acupuncture, acupressure, the electrical stimulation of needles, cupping or moxibustion, gua sha, and Tuina. Before any of these procedures are performed, my practitioner will discuss my treatment options and only proceed if my consent is given.
2. My practitioner has informed me of the risks and symptoms of treatments, which can include, but are not limited to: slight pain, light-headedness or nausea, soreness, bruising, bleeding or discolouration of the skin, and the possibility of other unforeseen risks. I freely accept the risks involved with my procedure.
3. I will inform my practitioner if I currently have or develop any major health issues, if I suffer from any type of major bleeding disorder, or if I use a pacemaker.
4. I understand that I must let my practitioner know if I am carrying, or believe to have any infectious agents, including but at not limited to HIV, TB and Hepatitis. In some cases where cross-infection is high, my practitioner may withhold treatment.
5. I understand that there are no guarantees for the results of treatments. Traditional Chinese Medicine does not often provide an instant cure. The length of my treatment depends on the severity of my condition. In some cases my symptoms may temporarily worsen before they begin to improve.
6. I am responsible for the full and prompt payment after services have been rendered.
7. I have discussed the content of this form with my practitioner. I acknowledge that I have asked any questions I may have and received answers I understand. By signing this form, I give my informed consent for Traditional Chinese Medicine treatments.

______________________________	______________________________
Patient Signature	Practitioner Signature
______________________________	______________________________
Date	Date

Consent to Collect and Release Information (Sample Form D)
Clinic Name/Practitioner Name/Registration # Clinic Address
Clinic Phone Number

I____, or my appointed representative_______________________________________
(Print) (Print)

☐ Consent ☐ Do not consent

for Clinic ___________________________________ to collect and release my general patient or medical information to other medical practitioners or health care providers/support workers, emergency personnel and/or any other relevant organizations.

In terms of information, the Clinic may collect any of the following:

- Contact information
- Personal or family medical history
- Medical insurance or billing/account information

In cases of emergencies or life threatening situations, medical or support staff workers may have to collect this information from family members or other listed contacts without your prior written consent.

How Your Information Will Be Used
Your personal information can be used or disclosed for the following reasons:

- For billing or account purposes
- To assist third-party insurance companies with insurance claims
- Referring your medical history to another health practitioner or health care provider
- To seek advice for potential treatment options
- To prevent or assist patients in cases of emergencies or threat to their health and safety
- To fulfill any obligations as mandated by law

Patient Access to information
I understand that my personal and medical history is available to me for my review under most circumstances. Cases where access to records be limited are:

- cases where access to information causes a threat to your life or personal health
- Where the law disallows access to information
- In the event where disclosure of information relates to any anticipated or actual legal proceedings or professional conduct proceedings.

[If applicable] I understand that a reproduction or translation fee may be incurred in accordance with the clinic's fee schedule.

Acknowledgment
I allow for medical personnel to use and disclose my information as outlined above.
I understand that I can access my personal health information except as outlined above.
I understand that I can withdraw my consent at any time, but it may directly affect the services I can receive. My personal information can still be used/disclosed if mandated by law.

Additional Comments or Restrictions: ____
____
____

______________________________	______________________________
Patient Signature	Witnessed
______________________________	______________________________
Date	Date

Patient Billing (Sample Form E)

<table>
<tr><th colspan="4">Clinic Name/Practitioner Name/Registration #
Clinic Address and Clinic Phone Number</th></tr>
<tr><td>Practitioner / Registration Number</td><td colspan="2"></td><td>Invoice Number</td><td></td></tr>
<tr><td>Patient Name</td><td colspan="2"></td><td>Invoice Date</td><td></td></tr>
<tr><td colspan="5"></td></tr>
<tr><td colspan="3">Items</td><td colspan="2">Amount</td></tr>
<tr><td colspan="3">Service/Procedure Received</td><td colspan="2"></td></tr>
<tr><td colspan="3"></td><td colspan="2">$</td></tr>
<tr><td colspan="3"></td><td colspan="2">$</td></tr>
<tr><td colspan="2">Equipment Used</td><td>Date Equipment Used</td><td colspan="2"></td></tr>
<tr><td colspan="2"></td><td></td><td colspan="2">$</td></tr>
<tr><td colspan="2"></td><td></td><td colspan="2">$</td></tr>
<tr><td colspan="2"></td><td></td><td colspan="2">$</td></tr>
<tr><td colspan="2"></td><td></td><td colspan="2">$</td></tr>
<tr><td colspan="3">Prescriptions and All Other Natural Health Products Sold</td><td colspan="2"></td></tr>
<tr><td colspan="3"></td><td colspan="2">$</td></tr>
<tr><td colspan="3"></td><td colspan="2">$</td></tr>
<tr><td colspan="3"></td><td colspan="2">$</td></tr>
<tr><td colspan="3"></td><td colspan="2">$</td></tr>
<tr><td colspan="3">Any Other Products Sold</td><td colspan="2"></td></tr>
<tr><td colspan="3"></td><td colspan="2">$</td></tr>
<tr><td colspan="3"></td><td colspan="2">$</td></tr>
<tr><td colspan="2"></td><td>Total:</td><td colspan="2">$</td></tr>
</table>

Equipment and Supplies Record (Sample Form F)

Clinic Name/Practitioner Name/Registration # Clinic Address and Clinic Phone Number			
Equipment / Supply	**Date Equipment Purchased**	**Date Equipment Decommissioned**	**Service Notes (if applicable)**

TCM Herbal Inventory Record (Sample Form G)

Clinic Name/Practitioner Name/Registration # *Clinic Address and Clinic Phone Number*				
TCM Herbal Name, Herbal Medicine Name and/or Natural Product Number (NPN)	**LOT Number**	**Date Purchased**	**Date of Expiry**	**Service Notes (if applicable)**

诊所记录的保存

2015 年 9 月 12 日
2019 年 3 月 2 日修订

熟悉附例，包括附表 A 道德准则和附表 B 执业标准，是每一位中医针灸管理局注册医师的责任。注册医师也要熟悉中医针灸管理局法理学课程手册和中医针灸执业安全课程手册。
该执业标准是用来结合并不是代替这些文件来阅读的。

目的

此政策的目的在于支持该执业标准，并以法理学课程手册第 3 部分 C (v) 和中医针灸执业安全课程手册中的第 3.7 风险管理-病人及病历为依据。

它叙述了管理局要求其注册医师保存记录的标准，以确保注册医师达到执业标准，从而保障公众的安全。它提出了管理局注册医师被要求保存的在诊治病人及其执业操作方面的必要记录。

注册总监、职员、质量保证委员会、调查委员会和纪律委员会将此政策用于 RSBC1996 年之医疗专业法（HPA）的解释和应用。

当该执业标准和基本法律之间有任何不一致时，法律优先。

背景

为了履行职业义务，管理局的注册医师必须为每一位病人保存准确、清晰和最新的记录，以便提供最合适的照顾和治疗。该执业标准的第一部分叙述的就是执业医师所必须保存的符合要求的记录。

病人有权认为他们的个人资料应当予以保密，他们可以要求一位相当谨慎的专业执业医师能够提供一个看管标准。

该执业标准的第二部分叙述了注册医师必须如何保存记录。（管理局细则的第六部分）

鸣谢

卑诗省中医针灸管理局衷心感谢安大略省中医师及针灸师管理局允许改编后的本执业准则在卑诗省使用。

保存记录的种类

1. 每日预约记录

一份书写或电子的每日预约记录必须包含：

- 日期
- 每位病人的姓，名和/或缩写
- 每位病人的就诊时间和/或诊疗所需时间

2. 病人档案

规定注册医师必须为每位病人保存一份保密的档案，包含有：

2.1. 病历摘要（样表 A）

此摘要的作用相当于一个病历记录的封面以给予病人总体病史一个印象。它列出了病人的基本资料，以便对病人的整体健康状况和最新进展能有一个快速参考。

每位病人必须有一份病历摘要。注册医师可以使用样表 A 以达到这个要求，或者也可以创建和使用自己的表格。病历摘要必须包含以下数据：

- 病人识别（姓名，地址，电话号码）
- 个人和家庭资料（出生日期，性别，职业，婚姻状况）
- 家庭的联系资料
- 紧急联系人资料
- 家庭医生（姓名，地址，电话号码）
- 既往史
- 风险因素
- 过敏/药物反应
- 持续健康状况
- 长期的治疗
- 病历摘要最后更新日期

2.2. 病历记录（样表 B）

病历记录为注册医师提供了对病人当前和过去之健康状况的清晰认识、确定的健康问题及之后的诊治疗程。准确、清晰和简洁的记录有利于后续治疗及防止出错。

注册医师可以使用样表 B，或者创建自己的病历记录，只要包含以下内容：

a) 病史

- 个人健康和病史（持续存在的问题、过去的疾病、手术、过敏、药物反应、处方药物、草药补充剂、维生素、非处方药物治疗等）
- 家族病史
- 专业诊断

b) 初步评估/诊断和治疗
- 现在症/主诉
- 体征和症状
- 中医诊断和治疗（中医病名，中医辨证）
- 治疗原则和对策
- 治疗计划（方式：针灸，中药，饮食，手法治疗），频率和持续时间。
- 给予病人的建议

c) 后续治疗
- 就诊日期
- 进展询问
- 中医辨证诊断
- 治疗方案的调整
- 禁忌
- 中药处方
- 针灸处方
- 辅助手段/治疗或使用的步骤及细节
- 病人对治疗的反应
- 记述病人拒绝遵从建议

d) 病人正在接受或已经接受服务的其他医护人员的与治疗相关的资料
- 推荐的医护人员（正规医疗专业人员）
- 姓名，地址和电话号码
- 其他相关的护理人员（如：私人护理）
- 姓名，地址和电话号码
- 与其他医护人员往来的通信内容

e) 检验/报告
- 由经手治疗的注册医师收集或提供的签名报告
- 从其他医护专业人员处索取及收到的报告
- 审核后, 为报告简签及写上日期

f) 病人同意治疗（样表 C）
病人有权获得足够的数据，以便对于是否接受治疗作出一个明智的决定。注册医师在采取任何行动之前必须确保他们的病人都知道、了解并同意他们的评估或治疗。

重要的是，知情同意要通过注册医师和病人之间的一个严肃对话达成。

为确保知情同意，注册医师必须在病人签字前向其解释病人同意治疗书的每一个部分。只是简单让病人阅读并签署同意治疗书是不够的。注册医师必须审阅其中的每一部分并解释

给病人听。注册医师可以使用样表 C，或者创建自己的病人同意治疗书，只要它包含以下数据：

- 病人自愿承认风险，随时可以选择撤回其同意并停止参与治疗
- 描述和解释可能会用于病人的服务、方法或过程
- 中药（方剂处方单）
- 可能出现的风险、副作用或与任何可能的治疗相关的后果
- 有一项要求病人告知执业医师过去或现在所有重大的健康问题
- 有一项要求病人透露是否正在或估计自己可能携带任何传染性病原体
- 有一项概略说明无法保证中医/针灸治疗的效果
- 有一项详述与诊病或治疗相关的费用
- 病人拒绝同意治疗的证据（视情况而定）
- 全面确定知情同意和协议的全部内容，授权执业医师开始治疗病人
- 病人的签名和日期
- 执业医师的签名和日期

g) 同意收集或披露资料 (样表 D)

注册医师永远都必须在获得病人的同意之后方可收集、 使用或披露其病人的个人健康数据，除非被个人信息保护法 (PIPA) 允许

注册医师可以使用样表 D 或创建自己的同意收集或披露资料书，只要它包含以下数据：

- 一个留给病人或其指定代表用印刷体书写他或她名字的空间
- 一份由病人向执业医师/诊所的确认，即同意收集或披露自己的资料给其他医护人员、护理员、急救人员或者其他有关机构。
- 病人的数据将被如何使用的说明
- 关于病人资料查阅的说明
- 复制或翻译记录的所有适当收费的说明
- 全面确定病人了解此同意书及他/她可随时撤回同意的资格
- 病人签名和日期
- 证人签名和日期

2.3. 病人收费记录（样表 E）

病人收费记录是有关注册医师为病人提供的服务和/或用品的计费或付费记录

注册医师可以使用样表 E，或者创建自己的病人收费记录表，只要它包含以下内容：

- 治疗日期
- 病人姓名
- 专业治疗费用
- 提供的治疗分项
- 向病人收费的所有中药处方、天然健康产品、、或所有其他类型产品的列表
- 使用了的设备逐项列表，
- 总计费用
- 实施治疗/提供用品的注册医师姓名和注册号

病人收费记录可被用作执业医师自己的记录或给予病人或任何其他合法的第三方（例如，代表病人支付的保险公司）。

2.4. 病人记录的维护与管理

一般原则

事项必须在看诊时或之后直接写到病人记录上。所有记录必须注明日期。施治注册医师不能将负责病人病情记录准确性的责任推卸给他人。

如果是学生正输入数据到病人记录中，输入的数据都必须由他们的指导医师签好字。该指导医师负责确保输入的数据完整和准确。

记录上的数据不能被删除或移除。与病人往来与病人的护理有关的书面交流都必须保存在病人档案中。记录可以手写、打字或以电子形式。如果手写，字迹必须清晰可辨。

记录、文件、报告必须包括：

- 日期
- 编号以识别病人
- 显示诊断/治疗者的身份
- 显示写记录者的身份
- 缩略语/符号的说明（如果使用了）。以及
- 被任何第三方，尤其是其他的管理局注册医师或其他医护人员容易理解

在病人记录中的材料必须有组织和编排，从某种意义上来说以便容易和迅速地检索及被管理，以确保安全性和保密性。

更改病历记录
在病人档案中的记录、文件、报告和数据不能被删除或移除。对病历作修改，施治注册医师或者负责人员都必须明确地指出更改的是什么以及谁做的更改。

更改不能被擦除或被涂改。取而代之的是，划一单线来穿过需要更改的条目，或者若是电子文件,应该使用一个「删去」字体。更改必须由更改人简签。如果更改是电子文件的，更改人的名字必须在记录中更改条目的旁边打出来。

病人数据和记录的移送
当被要求移送病人的数据时，必须由病人或病人的授权代表作出明确的书面同意，仅当某些例外（如：病人无能力) 时，资料方可移送。移送病人资料的成本将记账于病人。

病人查询记录
根据个人信息保护法（PIPA），病人有权查询自己的个人资料记录。施行治疗的注册医师有义务应病人的要求提供其数据及复印件，除非授权查询可能会导致严重危害病人的治疗或康复的风险，或严重伤害病人或其他人身体的风险 - 在这些情况下，执业医师应告知病人他们有权向资料和隐私专员投诉。

病人要求披露他/她的病历，必须签署一份同意书（见 2.2（g）所述）。在某些紧急情况下，该要求可能会被免除。

一般来说，应在与个人的家庭成员分享个人健康资料之前获得同意。但如果个人受伤、无能力或生病而不能提供同意，个人资料可被透露以用于与家人、朋友或其他可能的替代决策者联络的目的。

注册医师可以透露一个人的个人资料，如果他有合理的理由认为该透露对消除或减少对病人或其他人严重身体伤害的重大风险是必要的。

提供记录
根据管理局细则附表 B （注册医师的执业标准）第 4.4 章节，注册医师必须向病人解释他们的服务。如果有复制或翻译费用变化，注册医师必须在治疗开始前通知病人。

2.5. 设备，供应用品及库存记录

设备及供应用品（样表F-设备和供应记录）
使用的设备（包括如热灯，心肺复苏设备，秤和切片机等仪器），都必须根据其制造商或供货商列出的标准进行维护。相关数据都应保存在记录簿中。此外，注册医师必须详列、维护和保存一份清单：

- 用于病人服务的每台仪器或设备
- 使用过的设备灭菌记录（如拔罐器和/或其他涉及血液的设备）
- 其他所需设备的使用记录

中草药的库存（样表G-中药库存记录）

管理局希望注册医师非常谨慎地保管中草药的库存并控制它们的采购、供应和配发。由于因污染、过期及中草药毒性导致的对公众的潜在风险，必须保留准确的库存记录。

开中草药处方的注册医师必须保存中草药库存的详细清单，其中包括：

- 所购中草药之供货商的身份和联络信息
- 中草药的中文名、拼音、和植物学名或拉丁药名
- 只使用有效期限或到期日之前的中草药
- 确保中药处方都清晰易读，并包含必要的中药处方数据，内容易懂并且被安全配发、 使用和追踪
- 贮存地点（有毒中药要被分开存放，以防止未经许可的使用）
- 一个中药处方记录或者包含中药剂量、病人姓名及配发日期内容的病人记录
- 购买日期

记录的管理

1. 记录的易读性

记录可以是手写、打字、语音口述和转录、或以电子方式保存在计算机中的，只要保存记录的方式包含该政策规定的必需数据。

为卑诗省医疗保健计划（MSP）计费目的，诊所记录必须一直用英语保存。

2. 安全性和存储

记录的保密性和安全性必须认真对待。记录必须是手写或电子存储。

记录必须受到保护以防丢失、篡改、干预或未经许可的查阅。如果保存纸张记录，必须将它们存放在一个安全的地方，并且必须制定预防措施以确保文档的安全性。如果是保存电子记录，必须有备份文档和恢复规程及步骤。

3.　记录保留和销毁

根据管理局细则第 83（2），病人的档案必须保留到与病人最后一次沟通之后至少 10 年。如果病人是一个未成年人，则病人的档案必须保留至病人 19 岁生日之后的 10 年。

记录的销毁必须以可操控和保密的方式来完成。

与执业相关的其他文件，都应该保留十年的时间。

4.　停业/离开/辞职

注册医师必须遵守个人信息保护法以及管理局细则中的规定。

如果注册医师有意结束他或她的执业，他/她必须以合理的步骤, 给自己主要负责的每位病人发出适当的停业通知：

i. 确保每位病人的记录移送到注册医师的接替者或者另一位注册医师（如果病人这样要求）；或者
ii. 确保每位病人的记录以安全方式被保留或者被处理

打算停业、辞职或离开现有诊所的注册医师，在他/她将离开或结束执业已很确定后，必须尽快通知他/她的病人, 以便病人有机会找到其他执业医师。他们还必须协助转移病人服务给其他专业人员。这包括复印病历（由病人付费）并移交病人的病历给其他执业医师或直接交给病人一份病历副本。

可接受的通知方式是：

1) 在预约的时间亲自通知;
2) 写信给病人; 和/或
3) 打电话给病人。

注册医师也不妨使用以下补充方式通知，包括：

- 打印的通知，张贴在诊所一个即使已关门都还容易看得到的地方。
- 报纸广告; 和/或
- 诊所录音机留言

注意：如果注册医师已去世，其诊所可能会选择储存病人记录并会应病人对其数据的要求个别答复，或者可选择转移记录到即将作为托管人的其他执业医师。

其他资源

- *卑诗省限制法*
  http://www.bclaws.ca/EPLibraries/bclaws_new/document/ID/freeside/00_12013_01
- *卑诗省个人信息保护法（PIPA）*
  http://www.bclaws.ca/EPLibraries/bclaws_new/document/ID/freeside/00_03063_01
- *卑诗省信息自由与隐私保护法（FOIPPA）*
  http://www.bclaws.ca/EPLibraries/bclaws_new/document/ID/freeside/96165_00
- *医疗卫生保健规定*
  http://www.bclaws.ca/civix/document/id/complete/statreg/426_97
- *加拿大个人信息保护及电子文件法*
  http://laws-lois.justice.gc.ca/eng/acts/P-8.6/index.html
- *加拿大隐私法*
  http://laws-lois.justice.gc.ca/eng/acts/P-21/FullText.html
- *加拿大信息使用法*
  http://laws-lois.justice.gc.ca/eng/acts/A-1/FullText.htm

**中文翻译，仅供参考。英文版本是唯一的正式版本。
**本中文执业准则的内容如与英文准则的内容有任何差异，概以英文版本为准。

診所記錄的保存

2015 年 9 月 12 日
2019 年 3 月 2 日修訂

熟悉附例，包括附表 A 道德準則和附表 B 執業標準，是每一位中醫針灸管理局註冊醫師的責任。註冊醫師也要熟悉中醫針灸管理局法理學課程手冊和中醫針灸執業安全課程手冊。
該執業標準是用來結合併不是代替這些文件來閱讀的。

目的

此政策的目的在於支持該執業標準，並以法理學課程手冊第 3 部分 C (v) 和中醫針灸執業安全課程手冊中的第 3.7 風險管理-病人及病歷為依據。

它敘述了管理局要求其註冊醫師保存記錄的標準，以確保註冊醫師達到執業標準，從而保障公眾的安全。它提出了管理局註冊醫師被要求保存的在診治病人及其執業操作方面的必要記錄。

註冊總監、職員、質量保證委員會、調查委員會和紀律委員會將此政策用於 RSBC1996 年之醫療專業法（HPA）的解釋和應用。

當該執業標準和基本法律之間有任何不一致時，法律優先。

背景

為了履行職業義務，管理局的註冊醫師必須為每一位病人保存準確、清晰和最新的記錄，以便提供最合適的照顧和治療。該執業標準的第一部分敘述的就是執業醫師所必須保存的符合要求的記錄。

病人有權認為他們的個人資料應當予以保密，他們可以要求一位相當謹慎的專業執業醫師能夠提供一個看管標準。

該執業標準的第二部分敘述了註冊醫師必須如何保存記錄。（管理局細則的第六部分）

鳴謝

卑詩省中醫針灸管理局衷心感謝安大略省中醫師及針灸師管理局允許改編後的本執業準則在卑詩省使用。

保存記錄的種類

1. 每日預約記錄

一份書寫或電子的每日預約記錄必須包含：

- 日期
- 每位病人的姓，名和/或縮寫
- 每位病人的就診時間和/或診療所需時間

2. 病人檔案

規定註冊醫師必須為每位病人保存一份保密的檔案，包含有：

2.1. 病歷摘要（樣表 A）

此摘要的作用相當於一個病歷記錄的封面以給予病人總體病史一個印象。它列出了病人的基本資料，以便對病人的整體健康狀況和最新進展能有一個快速參考。

每位病人必須有一份病歷摘要。註冊醫師可以使用樣表 A 以達到這個要求，或者也可以創建和使用自己的表格。病歷摘要必須包含以下資料：

- 病人識別（姓名，地址，電話號碼）
- 個人和家庭資料（出生日期，性別，職業，婚姻狀況）
- 家庭的聯繫資料
- 緊急聯繫人資料
- 家庭醫生（姓名，地址，電話號碼）
- 既往史
- 風險因素
- 過敏/藥物反應
- 持續健康狀況
- 長期的治療
- 病歷摘要最後更新日期

2.2. 病歷記錄（樣表 B）

病歷記錄為註冊醫師提供了對病人當前和過去之健康狀況的清晰認識、確定的健康問題及之後的診治療程。準確、清晰和簡潔的記錄有利於後續治療及防止出錯。

註冊醫師可以使用樣表 B，或者創建自己的病歷記錄，只要包含以下內容：

a) 病史

- 個人健康和病史（持續存在的問題、過去的疾病、手術、過敏、藥物反應、處方藥物、草藥補充劑、維生素、非處方藥物治療等）
- 家族病史
- 專業診斷

b) 初步評估/診斷和治療
- 現在症/主訴
- 體征和症狀
- 中醫診斷和治療（中醫病名，中醫辨證）
- 治療原則和對策
- 治療計劃（方式：針灸，中藥，飲食，手法治療），頻率和持續時間。
- 給予病人的建議

c) 後續治療
- 就診日期
- 進展詢問
- 中醫辨證診斷
- 治療方案的調整
- 禁忌
- 中藥處方
- 針灸處方
- 輔助手段/治療或使用的步驟及細節
- 病人對治療的反應
- 記述病人拒絕遵從建議

d) 病人正在接受或已經接受服務的其他醫護人員的與治療相關的資料
- 推薦的醫護人員（正規醫療專業人員）
- 姓名，地址和電話號碼
- 其他相關的護理人員（如：私人護理）
- 姓名，地址和電話號碼
- 與其他醫護人員往來的通信內容

e) 檢驗/報告
- 由經手治療的註冊醫師收集或提供的簽名報告
- 從其他醫護專業人員處索取及收到的報告
- 審核後, 為報告簡簽及寫上日期

f) 病人同意治療（樣表 C）

病人有權獲得足夠的資料，以便對於是否接受治療作出一個明智的決定。註冊醫師在採取任何行動之前必須確保他們的病人都知道、瞭解並同意他們的評估或治療。

重要的是，知情同意要通過註冊醫師和病人之間的一個嚴肅對話達成。

為確保知情同意，註冊醫師必須在病人簽字前向其解釋病人同意治療書的每一個部分。只是簡單讓病人閱讀並簽署同意治療書是不夠的。註冊醫師必須審閱其中的每一部分並解釋

給病人聽。註冊醫師可以使用樣表 C，或者創建自己的病人同意治療書，只要它包含以下資料：

- 病人自願承認風險，隨時可以選擇撤回其同意並停止參與治療
- 描述和解釋可能會用於病人的服務、方法或過程
- 中藥（方劑處方單）
- 可能出現的風險、副作用或與任何可能的治療相關的後果
- 有一項要求病人告知執業醫師過去或現在所有重大的健康問題
- 有一項要求病人透露是否正在或估計自己可能攜帶任何傳染性病原體
- 有一項概略說明無法保證中醫/針灸治療的效果
- 有一項詳述與診病或治療相關的費用
- 病人拒絕同意治療的證據（視情況而定）
- 全面確定知情同意和協議的全部內容，授權執業醫師開始治療病人
- 病人的簽名和日期
- 執業醫師的簽名和日期

g) 同意收集或披露資料 (樣表 D)

註冊醫師永遠都必須在獲得病人的同意之後方可收集、 使用或披露其病人的個人健康資料，除非被個人信息保護法 (PIPA) 允許

註冊醫師可以使用樣表 D 或創建自己的同意收集或披露資料書，只要它包含以下資料：

- 一個留給病人或其指定代表用印刷體書寫他或她名字的空間
- 一份由病人向執業醫師/診所的確認，即同意收集或披露自己的資料給其他醫護人員、護理員、急救人員或者其他有關機構。
- 病人的資料將被如何使用的說明
- 關於病人資料查閱的說明
- 複製或翻譯記錄的所有適當收費的說明
- 全面確定病人瞭解此同意書及他/她可隨時撤回同意的資格
- 病人簽名和日期
- 證人簽名和日期

2.3. 病人收費記錄（樣表 E）

病人收費記錄是有關註冊醫師為病人提供的服務和/或用品的計費或付費記錄

註冊醫師可以使用樣表 E，或者創建自己的病人收費記錄表，只要它包含以下內容：

- 治療日期
- 病人姓名
- 專業治療費用
- 提供的治療分項
- 向病人收費的所有中藥處方、天然健康產品、、或所有其他類型產品的列表
- 使用了的設備逐項列表，
- 總計費用
- 實施治療/提供用品的註冊醫師姓名和註冊號

病人收費記錄可被用作執業醫師自己的記錄或給予病人或任何其他合法的第三方（例如，代表病人支付的保險公司）。

2.4. 病人記錄的維護與管理

一般原則

事項必須在看診時或之後直接寫到病人記錄上。所有記錄必須註明日期。施治註冊醫師不能將負責病人病情記錄準確性的責任推卸給他人。

如果是學生正輸入資料到病人記錄中，輸入的資料都必須由他們的指導醫師簽好字。該指導醫師負責確保輸入的資料完整和準確。

記錄上的資料不能被刪除或移除。與病人往來與病人的護理有關的書面交流都必須保存在病人檔案中。記錄可以手寫、打字或以電子形式。如果手寫，字跡必須清晰可辨。

記錄、文件、報告必須包括：

- 日期
- 編號以識別病人
- 顯示診斷/治療者的身份
- 顯示寫記錄者的身份
- 縮略語/符號的說明（如果使用了）。以及
- 被任何第三方，尤其是其他的管理局註冊醫師或其他醫護人員容易理解

在病人記錄中的材料必須有組織和編排，從某種意義上來說以便容易和迅速地檢索及被管理，以確保安全性和保密性。

更改病歷記錄

在病人檔案中的記錄、文件、報告和資料不能被刪除或移除。對病歷作修改，施治註冊醫師或者負責人員都必須明確地指出更改的是什麼以及誰做的更改。

更改不能被擦除或被塗改。取而代之的是，劃一單線來穿過需要更改的條目，或者若是電子文件,應該使用一個「刪去」字體。更改必須由更改人簡簽。如果更改是電子文件的，更改人的名字必須在記錄中更改條目的旁邊打出來。

病人資料和記錄的移送

當被要求移送病人的資料時，必須由病人或病人的授權代表作出明確的書面同意，僅當某些例外（如：病人無能力) 時，資料方可移送。移送病人資料的成本將記賬於病人。

病人查詢記錄

根據個人信息保護法（PIPA），病人有權查詢自己的個人資料記錄。施行治療的註冊醫師有義務應病人的要求提供其資料及複印件，除非授權查詢可能會導致嚴重危害病人的治療或康復的風險，或嚴重傷害病人或其他人身體的風險 - 在這些情況下，執業醫師應告知病人他們有權向資料和隱私專員投訴。

病人要求披露他/她的病歷，必須簽署一份同意書（見 2.2（g）所述）。在某些緊急情況下，該要求可能會被免除。

一般來說，應在與個人的家庭成員分享個人健康資料之前獲得同意。但如果個人受傷、無能力或生病而不能提供同意，個人資料可被透露以用於與家人、朋友或其他可能的替代決策者聯絡的目的。

註冊醫師可以透露一個人的個人資料，如果他有合理的理由認為該透露對消除或減少對病人或其他人嚴重身體傷害的重大風險是必要的。

提供記錄

根據管理局細則附表 B （註冊醫師的執業標準）第 4.4 章節，註冊醫師必須向病人解釋他們的服務。如果有複製或翻譯費用變化，註冊醫師必須在治療開始前通知病人。

2.5. 設備，供應用品及庫存記錄

設備及供應用品（樣表 F-設備和供應記錄）

使用的設備（包括如熱燈，心肺復甦設備，秤和切片機等儀器），都必須根據其製造商或供應商列出的標準進行維護。相關資料都應保存在記錄簿中。此外，註冊醫師必須詳列、維護和保存一份清單：

- 用於病人服務的每台儀器或設備
- 使用過的設備滅菌記錄（如拔罐器和/或其他涉及血液的設備）
- 其他所需設備的使用記錄

中草藥的庫存（樣表 G-中藥庫存記錄）

管理局希望註冊醫師非常謹慎地保管中草藥的庫存並控制它們的採購、供應和配發。由於因污染、過期及中草藥毒性導致的對公眾的潛在風險，必須保留準確的庫存記錄。

開中草藥處方的註冊醫師必須保存中草藥庫存的詳細清單，其中包括：

- 所購中草藥之供應商的身份和聯絡信息
- 中草藥的中文名、拼音、和植物學名或拉丁藥名
- 只使用有效期限或到期日之前的中草藥
- 確保中藥處方都清晰易讀，並包含必要的中藥處方資料，內容易懂並且被安全配發、 使用和追蹤
- 貯存地點（有毒中藥要被分開存放，以防止未經許可的使用）
- 一個中藥處方記錄或者包含中藥劑量、病人姓名及配發日期內容的病人記錄
- 購買日期

記錄的管理

1. 記錄的易讀性

記錄可以是手寫、打字、語音口述和轉錄、或以電子方式保存在電腦中的，只要保存記錄的方式包含該政策規定的必需資料。

為卑詩省醫療保健計劃（MSP）計費目的，診所記錄必須一直用英語保存。

2. 安全性和存儲

記錄的保密性和安全性必須認真對待。記錄必須是手寫或電子存儲。

記錄必須受到保護以防丟失、篡改、干預或未經許可的查閱。如果保存紙張記錄，必須將它們存放在一個安全的地方，並且必須制定預防措施以確保文檔的安全性。如果是保存電子記錄，必須有備份文檔和恢復規程及步驟。

3. 記錄保留和銷毀

根據管理局細則第 83（2），病人的檔案必須保留到與病人最後一次溝通之後至少 10 年。如果病人是一個未成年人，則病人的檔案必須保留至病人 19 歲生日之後的 10 年。

記錄的銷毀必須以可操控和保密的方式來完成。

與執業相關的其他文件，都應該保留十年的時間。

4. 停業/離開/辭職

註冊醫師必須遵守個人信息保護法以及管理局細則中的規定。

如果註冊醫師有意結束他或她的執業，他/她必須以合理的步驟, 給自己主要負責的每位病人發出適當的停業通知：

i. 確保每位病人的記錄移送到註冊醫師的接替者或者另一位註冊醫師（如果病人這樣要求）；或者
ii. 確保每位病人的記錄以安全方式被保留或者被處理

打算停業、辭職或離開現有診所的註冊醫師，在他/她將離開或結束執業已很確定後，必須盡快通知他/她的病人, 以便病人有機會找到其他執業醫師。他們還必須協助轉移病人服務給其他專業人員。這包括複印病歷（由病人付費）並移交病人的病歷給其他執業醫師或直接交給病人一份病歷副本。

可接受的通知方式是：

1) 在預約的時間親自通知;
2) 寫信給病人; 和/或
3) 打電話給病人。

註冊醫師也不妨使用以下補充方式通知，包括：

- 打印的通知，張貼在診所一個即使已關門都還容易看得到的地方。
- 報紙廣告; 和/或
- 診所答錄機留言

注意：如果註冊醫師已去世，其診所可能會選擇儲存病人記錄並會應病人對其資料的要求個別答覆，或者可選擇轉移記錄到即將作為托管人的其他執業醫師。

其他資源

- *卑詩省限製法*
  http://www.bclaws.ca/EPLibraries/bclaws_new/document/ID/freeside/00_12013_01
- *卑詩省個人信息保護法（PIPA）*
  http://www.bclaws.ca/EPLibraries/bclaws_new/document/ID/freeside/00_03063_01
- *卑詩省信息自由與隱私保護法（FOIPPA）*
  http://www.bclaws.ca/EPLibraries/bclaws_new/document/ID/freeside/96165_00
- *醫療衛生保健規定*
  http://www.bclaws.ca/civix/document/id/complete/statreg/426_97
- *加拿大個人信息保護及電子文件法*
  http://laws-lois.justice.gc.ca/eng/acts/P-8.6/index.html
- *加拿大隱私法*
  http://laws-lois.justice.gc.ca/eng/acts/P-21/FullText.html
- *加拿大信息使用法*
  http://laws-lois.justice.gc.ca/eng/acts/A-1/FullText.htm

**中文翻譯，僅供參考。英文版本是唯一的正式版本。
**本中文執業準則的內容如與英文準則的內容有任何差異，概以英文版本為準。