

42 C.F.R. § 418.104

Condition of participation: Clinical records.

A clinical record containing past and current findings is maintained for each hospice patient. The clinical record must contain correct clinical information that is available to the patient's attending physician and hospice staff. The clinical record may be maintained electronically.

- (a) Standard: Content. Each patient's record must include the following:
- (1) The initial plan of care, updated plans of care, initial assessment, comprehensive assessment, updated comprehensive assessments, and clinical notes.
- (2) Signed copies of the notice of patient rights in accordance with § 418.52 and election statement in accordance with § 418.24.
- (3) Responses to medications, symptom management, treatments, and services.

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