Enclosure #2

Taken from the College of Physicians & Surgeons
Bylaw 46

46. **Medical Records**

All members of the College of Physicians and Surgeons of Saskatchewan shall keep, as a minimum requirement, the following records in connection with their practice:

(1) In respect of each patient a legibly written or typewritten record setting out:

(a) the name, address, birthdate and Provincial Health Care Number of the patient;

(b) the date that the member sees the patient;

(c) a record of the assessment of the patient which includes the history obtained, particulars of the physical examination, the investigations ordered and where possible, the diagnosis; and

(d) a record of the disposition of the patient including the treatment provided or prescriptions written by the member, professional advice given and particulars of any referral that may have been made. Prescribing information should include the name of medication, strength, dosage and any other directions for use.

(2) The patient record should include every report received respecting a patient from another member or other health professional.

(3) The records are to be kept in a systematic manner.

(4) The records must be completed in a timely manner.

(5) The records may be made and maintained in an electronic computer system providing

(a) the system provides a visual display of the recorded information,

(b) the system provides a means of access to the record of each patient by the patient's name and if the person has a Provincial Health Care Number, by the health number,

(c) the system is capable of printing the recorded information promptly,

(d) the system is capable of visually displaying the recorded information for each patient in chronological order,

(e) the system maintains an audit trail that:

(i) records the date and time of each entry of information for each patient

(ii) indicates any changes in the recorded information,

(iii) preserves the original content of the recorded information when changed or updated, and

(iv) is capable of being printed separately from the recorded information of each patient

(f) the system includes a password or otherwise provides reasonable protection against unauthorized access, and

(g) the system backs up files and allows the recovery of backed up files or otherwise provides reasonable protection against loss of, damage to and inaccessibility of information.

(6) (a) A member shall retain the records required by this regulation for six years after the date of the last entry in the record. Records of pediatric patients shall be retained until 2 years past the age of majority or 6 years after the date last seen, whichever may be the later date.

(b) A member who ceases to practice shall:

(i) transfer the records to a member with the same address and telephone number; or

(ii) transfer the records to:

1. another member practicing in the locality, or
2. a medical records department of a health care facility, or
3. a secure storage area with a person designated to allow physicians and patients reasonable access to the records,

after publication of a newspaper advertisement indicating when the transfer will take place.