Records Content

Standards of Practice of the Yukon Medical Council (“the Council”) are the minimum standards of professional behavior and ethical conduct expected of all physicians registered in the Yukon. Standards of Practice will be referenced in the management of complaints and in discipline

(1) A patient record must contain enough information for another physician, or other regulated healthcare provider, to be sufficiently informed of the care being provided including:

- (a) clinical notes;
- (b) laboratory and imaging reports;
- (c) pathology reports;
- (d) referral letters and consultation reports;
- (e) hospital summaries; and
- (f) surgical notes.

(2) A patient record of clinical care in a medical practice must contain or provide reference to the following information, at a minimum:

- (a) the patient's name, address, phone numbers, date of birth, gender, and personal healthcare number;
- (b) dates seen and the identity of the physician attending the patient on those dates;
- (c) documentation of presenting complaints and applicable functional inquiry;
- (d) significant prior history;
- (e) current medications, allergies and drug sensitivity;
- (f) relevant social history including alcohol or drug use or abuse;
- (g) relevant family history;
- (h) findings on physical examination, including relevant abnormalities or absence thereof;
- (i) diagnoses (tentative, differential or established);
- (j) treatment advised and provided, including medication prescribed;
- (k) when a prescription is issued:
    - (i) the name of the medication;
    - (ii) the dose of medication to be taken at each administration;
    - (iii) the frequency of administration;
    - (iv) the duration of the period for which the patient is to take the medication; and
    - (v) whether or not refills have been issued.
- (l) investigations ordered and results obtained;

Terms used in the Standards of Practice:

- *Physician* means any person who is registered or who is required to be registered under the Medical Profession Act.
- *Must* refers to a mandatory requirement.
- *May* means that the physician may exercise reasonable discretion.
- *Patient* includes, where applicable, the patient’s legal guardian or substitute decision maker.

(m) instructions, precautions and advice to the patient, including instructions for follow-up care; and

(n) response of the patient to the advice given, if refused.

(3) A physician must ensure a patient record is legible, and in English.

(4) When information in a patient record is changed, added to or deleted (collectively the "alteration") after the fact, the original entry, the identity of the person making the alteration, and the date of the alteration must be included in the patient record.

(5) In the case of a telephone consultation between two physicians with respect to a specific patient, the referring physician must document a summary of the consultation on the patient record, and the consultant must document enough information as is necessary to validate that the consultation occurred.

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