College of
Naturopathic Physicians
of British Columbia

Standard on Health Care Records and Receipts

Requirements for health care records:

1. A registrant must

    a. keep records in English,

    b. keep all patient records in "SOAP" format (an acronym for subjective, objective, assessment, and plan),

    c. keep a clinical record for each patient containing a clear record of

        i. the patient's name, gender, personal health number, date of birth, address, dates of attendance, dates of interactions (e.g., telephone conversations or emails) with the registrant, family contact information, emergency contact information, family doctor (name, address, and phone number), past medical history, family health history, health risk factors, allergies/drug reactions, ongoing health conditions, long-term treatment, and date of last update of the clinical record,

        ii. if the patient is accompanied by one or more individuals involved in the patient's decision making, then the names of, relation to the patient of, and other relevant information about those individuals,

        iii. sufficient information to clearly explain why the patient came to see the registrant, what the registrant learned from both the medical history and the physical examination, and any other professional's diagnosis (including records and test results),

        iv. the registrant's assessments and observations,

        v. what investigations the registrant ordered,

vi. any tests or reports,

vii. either the differential diagnosis or diagnosis made,

viii. the specifics of any treatment plan, recommendation, medication (including name, strength, dosage form, quantity, and directions for use), follow-up plan, and contraindications,

ix. consultations requested,

x. the patient's consent to treatment,

xi. the charge made for the service rendered,

xii. the patient's reaction to treatment,

xiii. any other health care practitioners who were with the registrant when the registrant saw the patient,

xiv. referrals or transfers of care,

xv. who entered the information in the record, and

xvi. the signature of the registrant (may be electronic),

d. during, immediately following, or as soon as possible after, a patient's visit, enter the information from the visit into the patient's record,

e. for each day, keep a day book, daily diary, appointment sheets, or equivalent containing the names of patients seen or treated, or in respect of whom professional services are rendered, including the date and type of the service rendered,

f. clearly document and maintain as part of the medical record all verbal and written communication (including but not limited to in-person, telephone, video chat, text message, email message, letter, and fax) related to clinical care,

g. ensure that every part (e.g. each page or every electronic file) of a health care record has a reference identifying the patient or the patient's health record, and

h. keep all records either

i. typed or legibly written in ink and filed in suitable systematic permanent form such as books, binders, files, cards, or folders, or

ii. in electronic form, compliant with the policies and guidelines of the College with respect to the creation, maintenance, security, disposition, and recovery of electronic medical records.

2. The information kept in the records must be capable of being reproduced promptly in written form and the material so reproduced, either by itself or in conjunction with other records, must constitute an orderly and legible permanent record that would provide, without delay, the information required under sections 1.c and 1.e, and the record keeping system must audit or record any subsequent changes made.

3. A registrant must make all records and all other relevant practice records, documents, and writings, available at reasonable hours for inspection by the College's board, any College committee, or any person or body acting on behalf of or under the direction of the College, the College's board, or any committee of the College, and must permit any such body or person to make copies or remove records temporarily for the purpose of making copies.

4. A registrant must keep all records in accordance with all Federal and British Columbia statutes applicable to the practice of naturopathic medicine including, without limitation,

a. the *Personal Information Protection Act* of British Columbia,

b. the *Personal Information Protection and Electronic Documents Act* of Canada,

c. the *Privacy Act*, and

d. the *E-Health (Personal Health Information Access and Protection of Privacy) Act* of British Columbia.

Requirements for receipts:

5. A registrant's receipt for services and/or goods provided by the registrant to the patient must be in English and contain the

a. date of service,

b. date of payment,

c. name of the patient,

d. professional fees charged,

e. itemized services offered,

f. list and cost of any medications, products, or devices billed or given to the patient,

g. itemized list and cost of equipment, if prescribed,

h. total payment charged, and

i. name and registration number of the registrant performing the service/providing the product(s) or device(s), and name and address of that registrant's place of practice.

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