



Record Keeping Checklist

OTs are accountable for meeting practice standards. This Checklist is intended to support OTs in meeting the Standards for Record Keeping by providing a quick reference with a focus on administration. Not all requirements are included in the Checklist. This Checklist should be used in conjunction with the Standards for Record Keeping to ensure performance expectations are met.

Record Management

I am the:

- Health Information Custodian (HIC) Agent of the Health Information Custodian

Organization and Administration

Each record is:

- Legible and understandable Dated and systematically organized Signed with the appropriate designation

Clinical Record Information

Each record includes:

- | | |
|---|---|
| <input type="checkbox"/> Client's full name, address and unique identifier (e.g. date of birth, health record/claim number) | <input type="checkbox"/> Record of occupational therapy interventions |
| <input type="checkbox"/> Referral source | <input type="checkbox"/> Progress notes (if applicable) |
| <input type="checkbox"/> Relevant health and social history | <input type="checkbox"/> References to any specific care maps or clinical pathways |
| <input type="checkbox"/> Date of each professional encounter with the client | <input type="checkbox"/> Defined acronyms and abbreviations |
| <input type="checkbox"/> Receipt of delegated controlled acts | <input type="checkbox"/> Notation of any modifications, errors, revisions and additions |
| <input type="checkbox"/> Transfer of care to others | <input type="checkbox"/> All relevant communications regarding the client |
| <input type="checkbox"/> Record of occupational therapy assessments and/or results | <input type="checkbox"/> Discharge information or discontinuation note (if applicable) |
| <input type="checkbox"/> Record of transfer or assignment of care to others | <input type="checkbox"/> Client identifiers on each part of the record |

Privacy and Access

- Only information relevant to the OT intervention is collected
 Process exists to facilitate client access to his or her personal health information

Confidentiality and Security

Each record is:

- Securely stored and managed to prevent unauthorized access
 In compliance with legislation, organizational policies and procedures related to the security of records

Consent

Informed consent obtained and documented for:

- Assessment Intervention Collection, Use and Disclosure of Personal Health Information
 Involvement of other care providers

Retention and Destruction

- Records are retained for 10 years or age of 18 + 10 years for client's under the age of 18
 Records are securely destroyed after retention requirement is met

Financial Records

- Client name Date of service Service or product provided and associated fees
 Date and method of payment

Equipment Records

- Record of equipment maintenance activities or maintenance protocol (if applicable)