**Section 250.1260 Operating Room Register and Records**

a) An operating room log or register, including those created by electronic means, shall be provided and maintained on a current basis. If the register is created by electronic means, then safeguards to protect the integrity and confidentiality of these records must be in place. The operating room log or register shall contain the date of the operation, name and number of patient, names of surgeons and surgical assistants, name of anesthetist, type of anesthesia given and pre- and post-operative diagnosis, type of surgical procedure, operating room number and the presence or absence of complications in surgery.

b) The medical staff shall establish procedures to ensure that preoperative and postoperative medical records are completed in a timely and accurate manner. A properly executed consent for the proposed surgical or diagnostic procedure, including a consent for anesthesia services, shall be in the patient's chart prior to surgery. Except in an emergency, a complete history and physical work-up shall be recorded in the chart of every patient prior to surgery.

c) The medical record of the patient shall be available in the operating suite and post-anesthesia area.

d) An operative report describing techniques and findings shall be written or dictated immediately following surgery and signed by the surgeon as soon after transcription as possible.

(Source: Amended at 23 Ill. Reg. 13913, effective November 15, 1999)