**Section 250.2290 Special Medical Record Requirements for Psychiatric Hospitals and Psychiatric Units of General Hospitals or General Hospitals Providing Psychiatric Care.**

Medical records must stress the psychiatric components of the patient's condition and care including history of findings and treatment rendered for the psychiatric condition for which the patient is hospitalized.

a) Identification data must include the patient's legal status.

b) A provisional or admitting diagnosis must be made on every patient at the time of admission and include the diagnoses of intercurrent diseases as well as the psychiatric diagnoses.

c) Data from all pertinent sources must be included in addition to data obtained from the patient.

d) The psychiatric evaluation, including a medical history must contain a record of mental status and note the onset of illness, the circumstances leading to admission, attitudes, behavior, estimate of intellectual functions, memory functioning, orientation, and an inventory of the patient's assets in descriptive, not interpretive, fashion.

e) A complete neurological examination must be recorded at the time of the admission physical examination, when indicated.

f) The social service records, including reports of interviews with patients, family members and others, must provide an assessment of home plans and family attitudes, and community resource contacts with appropriate recommendations for family and/or community resource involvement, as well as a social history.

g) Reports of consultations, reports of electroencephalograms and other pertinent reports of special studies must be included in the record.

h) The patient's comprehensive treatment plan must be recorded, based on an inventory of the patient's strengths as well as his disabilities, and must include a substantiated diagnosis in the terminology of the American Psychiatric Association's Diagnostic and Statistical Manual, (DSM-3), short-term and long range goals, and the specific treatment modalities utilized as well as the responsibilities of each member of the treatment team in such a manner that it provides adequate justification and documentation for the diagnoses and for the treatment and rehabilitation activities carried out.

i) The treatment received by the patient must be documented in such a manner and with such frequency as to assure that all active therapeutic efforts such as individual and group psychotherapy, drug therapy, milieu therapy, occupational therapy, recreational therapy, industrial or work therapy, nursing care and other therapeutic interventions are included.

j) Progress notes must be recorded by the physician, clinical psychologist, nurse, social worker and by others significantly involved in active treatment modalities. The notes must contain recommendations for revisions in the treatment plan as indicated as well as precise assessment of the patient's progress in accordance with the original or revised treatment plan.

k) The discharge summary must include a recapitulation of the patient's hospitalization and recommendations from appropriate services concerning follow-up or aftercare as well as a brief summary of the patient's condition on discharge.

l) It is recommended that the unique confidentiality requirements of a psychiatric record be recognized and safeguarded in any unitized record keeping system of a general hospital.

(Source: Amended at 11 Ill. Reg. 10642, effective July 1, 1987)