STATE OF MONTANA
DEPARTMENT OF CORRECTIONS
POLICY DIRECTIVE

Policy No. DOC 4.5.37	Subject: **OFFENDER HEALTH RECORD FORMAT AND CONTENT**
Chapter 4: FACILITY/PROGRAM SERVICES	Page 1 of 3
Section 5: Clinical Services	Effective Date: July. 1, 1998
Department Director Signature: /s/ Brian Gootkin	Revised: 4/19/2021
Medical Director Signature: /s/ Dr. Paul Rees	
Clinical Services Division Administrator Signature: /s/ Connie Winner	

I. POLICY

The Department of Corrections facility health care units will establish and maintain complete and comprehensive offender health care records.

II. APPLICABILITY

All secure care facilities Department-owned and contracted, as specified in contract.

III. DEFINITIONS

Health Care Providers – Licensed health care providers (e.g., physicians, nurses, psychiatrists, dentists, and mental health practitioners), including contracted or fee-for-service providers, responsible for offender health care and treatment.

Health Care Record – Documentation by health care staff of preventive and clinical offender health care services.

Health Care Staff – Includes licensed health care providers and non-licensed health care staff (e.g., medical records staff, health care aides) responsible for offender health care administration and treatment.

Health Policy Team – A team consisting of the Department medical director, dental director, mental health or psychiatric representative, health services bureau chief, managed care RN, chief facility health officer, and facility administrator.

IV. DEPARTMENT DIRECTIVES

A. Initial Health Record

1. Upon admission, medical records staff will compile an offender health care record to include all medical, dental, and mental health information.

2. The Department health policy team will establish guidelines for the organization of the health care record.

B. Health Care Record Content

1. The health care record will contain all offender health-related information to include:

   a. identifying information (e.g., name, DOC ID number, date of birth, gender);

b. a problem list containing medical and mental health diagnoses, treatments, and known allergies;
c. admission screening and health assessment forms;
d. progress notes of all significant findings, diagnoses, treatments, and dispositions;
e. provider orders for prescribed medications and medication administration records;
f. laboratory and x-ray reports and diagnostic studies;
g. flow sheets;
h. consent and refusal forms;
i. release of information forms;
j. reports of specialty consultations and off-site referrals;
k. hospital and inpatient treatment discharge summaries;
l. special needs treatment plans, if applicable; and
m. immunization records, if applicable;
n. patient's condition (e.g., poor, fair, good);
o. patient status (e.g., stable improving, deteriorating);
p. patient education provided;
q. type and frequency of diagnostic testing and therapeutic regimens;
r. clinical justification for any deviation from established protocol; and
s. criminal justice information that is pertinent to clinical decisions is available to qualified health care professionals.

2. Where mental health and dental records are separate from medical records, a process ensures that pertinent information is shared. At a minimum, a listing of current problems and medications is common to all medical, dental, and mental health records of an offender.

C. Documentation

1. Health care providers will document in the health care record:

   a. all offender health encounters in accordance with guidelines established by the Department health policy team and facility health care unit procedures;
   b. all off-site care on a referral form approved by the Department medical director; and
   c. all consultant's reports, including diagnostic findings and recommendations; and
   d. signature and title of each documenter.

D. Health Record Confidentiality

1. Health care staff will ensure that:
   a. offender health care records are maintained separately from other offender records;
   b. health care record information is only released in accordance with *DOC Policies 1.5.6, Offender Records Access and Release,* and *4.5.38, Offender Health Record Access, Release, and Retention*; and
   c. Documentation that health staff, non-health staff, and custody staff have received training in maintain patient confidentiality.

E. Record Reactivation

Upon admission of re-incarcerated offenders, health care staff will reactivate the previous health care record, if available.

V. CLOSING

Questions concerning this policy should be directed to the health services bureau chief.

VI. REFERENCES

A. P-A-08, P-D-08, P-F-01, P-F-02; National Commission on Correctional Health Care Standards, 2018

B. ACA Standards for Juvenile Correctional Facilities, 2003

C. DOC Policies 1.5.6, Offender Records Access and Release; 4.5.38, Offender Health Record Access, Release, and Retention

D. MH-H-01, MH-H-02, MH-H-03; National Commission on Correctional Mental Health Services in Correctional Facilities, 2015

E. Y-H-01, Y-H-02, Y-H-03; National Commission on Correctional Health Services in Juveniles Detention and Confinement Facilities, 2015

VII. ATTACHMENTS

None