



Standards for the clinical structure and content of patient records

July 2013



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**Royal College
of Physicians**

**Developed by the Health Informatics Unit,
Clinical Standards Department, Royal College of Physicians**

The Health and Social Care Information Centre

From 1 April 2013, the Health and Social Care Information Centre (HSCIC) was made responsible for some of the functions previously undertaken by the Department of Health Informatics Directorate (DHID). This included the Clinical Data Standards Assurance (CDSA) programme. The CDSA programme brought together the clinical and professional communities in health and social care, patient representatives and technology resources to ensure that electronic health records reflected professional practice, and supported improved patient outcomes and safety.

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Introduction

This document describes standards for the structure and content of patient records, covering hospital referral letters, inpatient clerking, handover communications, discharge summaries and outpatient letters. They have been developed using published evidence and consultation with doctors, patients, nurses and allied healthcare professionals. The standards were signed off as fit for purpose for the whole medical profession by the Academy of Medical Royal Colleges (www.aomrc.org.uk) in April 2013.

The rising demands on healthcare systems and associated costs require a much more efficient and transparent means of recording, transmitting and accessing reliable clinical information in order to manage and deliver high quality care to patients, and populations.

The Francis Report (www.midstaffspublicinquiry.com) has emphasised the need for better information and highlighted the risks that increasing service pressures bring to patients, particularly if there is more attention paid to meeting service targets than ensuring that quality of individual patient care is maintained.

The challenges can only be met by the development and use of electronic health records (EHRs) in which data are recorded consistently across all contexts. The implementation of national standards for the clinical structure and content will facilitate shared care, enable interoperability between locations and contexts, and yield comparable data to support the management and monitoring of services realising benefits for patients, clinicians and services (www.rcplondon.ac.uk/projects/healthcare-record-standards).

Standardised electronic health records

Clinical care, service delivery and management

In 2013 NHS England set challenging targets, for paperless communications between primary and secondary care by 2015, and a paperless NHS by 2018. To record clinical information in a way that can be shared and re-used safely in an electronic environment, the structure must be standardised. For this to be realistically achievable, the standards for structure must reflect the way that patients and clinicians work together to the common goal of best practice and high quality care. This necessity has been recognised by the establishment of an independent Professional Record Standards Body (www.theprs.org.uk) to oversee rigorous development and maintenance of health and social care records (www.rcplondon.ac.uk/resources/joint-working-group-report).

First and foremost, electronic health records (EHRs) must support safe, high quality care, delivered in partnership between the patient and professionals, but in addition to supporting the care of the individual, there are many other uses of the data recorded in clinical records. These include clinical audit, management, planning, policy, commissioning and research. For all uses, the data must be fit for purpose and the necessary information governance and consent properly addressed. There is, however, abundant evidence that data quality is currently far from perfect, limiting the credibility of routinely collected data used for these additional purposes.

Information technology has the potential to deliver high quality information for these purposes, but to do so, the key data relating to the core transactions of healthcare – the record of the patient/clinician dialogue and the resulting decisions and actions taken – must be recorded accurately and be accessible to both patients and clinicians in all contexts in which care is delivered. To enable this, the EHR must be patient focused, and hold data recorded at the point of care using national standards and definitions, as set out by the Academy of Medical Royal Colleges in 2008 (www.aomrc.org.uk/publications/statements/doc_view/217-academy-statement-the-case-and-vision-for-patient-focused-records.html).

Research

Many studies have shown that imperfect data quality currently limits the research value of routinely collected data to the analysis of very large populations. However, there would be considerable benefits to patients and patient care through access to NHS-wide anonymised clinical datasets for the advancement of science and development of new medicines and technologies. Better quality phenotypic data will open up huge possibilities to answer research questions through data linkage, provided the data are recorded using national standards and definitions.

Developing the standards

These standards were developed in extensive consultation with representatives from the medical profession and specialist societies; healthcare professionals from multidisciplinary backgrounds; patients; carers and health information technology professionals.

Consultations were carried out via online surveys and multi-stakeholder project workshops (www.rcplondon.ac.uk/projects/healthcare-record-standards). The development programme, the Clinical Documentation and Generic Record Standards (CDGRS) programme, was commissioned by the Health and Social Care Information Centre (originally NHS Connecting for Health) in England. It was led by the Health Informatics Unit (HIU) of the Royal College of Physicians, with the aim of producing evidence- and consensus-based national standards for the structure and content of clinical records.

The standards have been endorsed as fit for purpose by 50 organisations that give professional leadership to the medical, nursing and clinical professions. They were signed off as fit for purpose for the whole medical profession by the Academy of Medical Royal Colleges (www.aomrc.org.uk) in April 2013.

The CDGRS programme has also produced further technical information (www.rcplondon.ac.uk/resources/standards-admission-handover-discharge-outpatient-and-referral-technical-annex) and more detailed information on medication and medical device records (www.rcplondon.ac.uk/resources/medications-and-medical-device-records).

The standards

The standards consist of a list of clinical record headings and a description of the information that should be recorded under each heading. Individual specialties and services will require headings and information in addition to, and different from, these generic standards. The additional heading standards will be developed by those specialties and should be accommodated under the generic headings.

04

Using the standards

Organisation of the standards

The standards are organised in a series of sections:

- The full set of record headings identifying where they are used in admission, handover, discharge, outpatient, referral records and communications and in the priority core headings (Section 1).
- **Admission:** the clinical information recorded in the hospital admission record (Section 2).
- **Handover:** handover of patient care from one professional or team to another, including hospital at night, weekend and consultant team to consultant team (Section 3).
- **Discharge:** the clinical information recorded in the discharge record and included in the discharge summary communication from hospital to GP and patient (Section 4).
- **Outpatient:** the clinical information recorded in an outpatient setting, including the initial and follow-up outpatient visits, and the information included in the outpatient letter to the GP and patient. The outpatient standards also include the administrative information that precisely defines the attributes of outpatient and ambulatory care sessions (Section 5).
- **Referral:** the referral headings are primarily intended for recording the clinical information in referral communications between GPs and hospital doctors, copied to the patient. However, they may be used for other types of referral (Section 6).
- **Core:** the core clinical headings are those that are the priority for inclusion in electronic health records (EHRs), as they are generally items that are the priority for coding using SNOMED CT (Section 7).

The standards in practice

A full EHR should include all the headings listed above, which will be displayed for data recording, reviewing and communicating in an order appropriate for the context. Not all headings will need to be used in all care settings or circumstances, and the order in which they appear in EHR applications, communications and letters can be agreed by system providers and end users.

All EHRs should ensure that for every record entry, the date, time and the identity of the person making the entry should be automatically recorded.

Section 1: All record headings

The full set of record headings (ie names and clinical descriptions for those headings which are included in one or more of admission, handover, discharge, outpatient, referral and core headings) is listed below.

Columns throughout these tables labelled 'C' indicate the core headings; those labelled 'A' indicate the admission record headings; those labelled 'H' indicate the handover record headings; those labelled 'D' indicate the discharge record headings; those labelled 'O' indicate the outpatient record headings; and those labelled 'R' indicate the referral record headings. '0' denotes absence and '1' denotes the presence of the preferred heading.

| GP practice | | | | | | | |
|------------------------|--|---|---|---|---|---|---|
| Subheadings | Clinical description | C | A | H | D | O | R |
| GP name | Where the patient or patient's representative offers the name of a GP as their usual GP. | 1 | 1 | 1 | 1 | 1 | 1 |
| GP practice details | Name, address, email, telephone number, fax of the patient's registered GP practice. | 1 | 1 | 1 | 1 | 1 | 1 |
| GP practice identifier | National code which identifies the practice. | 1 | 1 | 1 | 1 | 1 | 1 |

| Referral details | | | | | | | |
|-------------------------------|--|---|---|---|---|---|---|
| Subheadings | Clinical description | C | A | H | D | O | R |
| Referrer details | Name, designation, organisation and contact details of referrer. If not an individual, this could be, eg, GP surgery, department, specialty, subspecialty, educational institution, mental health etc. Also needs to include self-referral. | 0 | 1 | 0 | 1 | 1 | 1 |
| Referral to | Name, designation and organisation. If not an individual, this could be a service, eg, GP surgery, department, specialty, subspecialty, educational institution, mental health etc. | 0 | 0 | 0 | 0 | 1 | 1 |
| Referral method | A method of referral is the form in which a referral is sent and received. This may be a letter, email, transcript of a telephone conversation, Choose and Book, in person (self-referral), unknown etc. | 0 | 0 | 0 | 0 | 1 | 1 |
| Person to attend with patient | Identify others who will/may accompany the patient, eg, relative, carer, chaperone. Includes: <ul style="list-style-type: none">• name• relationship (friend, relative, etc)• role (patient advocate, chaperone etc)• attendee's special requirements. | 0 | 0 | 0 | 0 | 0 | 1 |
| Attachments | Documents included as attachments which accompany the communication. | 0 | 0 | 0 | 0 | 0 | 1 |

(continued overleaf)

| Subheadings | Clinical description | C | A | H | D | O | R |
|-----------------------------|---|----------|----------|----------|----------|----------|----------|
| Referral criteria | Records whether specific criteria required for referral, to a particular service, have been met (may be nationally or locally determined). | 0 | 0 | 0 | 0 | 0 | 1 |
| Details of other referrals | Other referrals related to this or associated conditions. | 0 | 0 | 0 | 0 | 0 | 1 |
| Patient demographics | | | | | | | |
| Subheadings | Clinical description | C | A | H | D | O | R |
| Patient name | The full name of the patient. Also patient preferred name: the name by which a patient wishes to be addressed. | 1 | 1 | 1 | 1 | 1 | 1 |
| Date of birth | The date of birth of the patient. | 1 | 1 | 1 | 1 | 1 | 1 |
| Patient sex | Sex at birth. Determines how the individual will be treated clinically. | 1 | 1 | 1 | 1 | 1 | 1 |
| Gender | As the patient wishes to portray themselves. | 1 | 1 | 1 | 1 | 1 | 1 |
| Ethnicity | The ethnicity of a person as specified by the person. | 1 | 1 | 1 | 1 | 1 | 1 |
| NHS number | The unique identifier for a patient within the NHS in England and Wales. | 1 | 1 | 1 | 1 | 1 | 1 |
| Other identifier | Country specific or local identifier, eg, Community Health Index (CHI) in Scotland. | 1 | 1 | 1 | 1 | 1 | 1 |
| Patient address | Patient usual place of residence. | 1 | 1 | 1 | 1 | 1 | 1 |
| Patient telephone number | Telephone contact details of the person. To include, eg, mobile, work and home number if available. | 1 | 1 | 1 | 1 | 1 | 1 |
| Patient email address | Email address of the patient. | 1 | 1 | 1 | 1 | 1 | 1 |
| Communication preferences | Preferred contact method, eg, sign language, letter, phone, etc. Also preferred written communication format, eg, large print, braille. | 1 | 1 | 1 | 1 | 1 | 1 |
| Relevant contacts | Eg next of kin, main informal carer, emergency contact. Name, relationship and contact details. | 1 | 1 | 1 | 1 | 1 | 1 |
| Special requirements | | | | | | | |
| Subheadings | Clinical description | C | A | H | D | O | R |
| Special requirements | Eg level of language (literacy); preferred language (interpreter required)/ambulance required/other transport arrangements required/any other special requirements. | 0 | 1 | 1 | 1 | 1 | 1 |

| Participation in research | | C A H D O R |
|-----------------------------------|--|---|
| Subheadings | Clinical description | C A H D O R |
| Participation in research | This is to flag participation in a clinical trial. This may include whether participation in a trial has been offered, refused or accepted, the name of the trial, drug/intervention tested, enrolment date, duration of treatment and follow up, and contact number for adverse events or queries. | 1 1 1 1 1 1 |
| Content specific headings | | C A H D O R |
| Subheadings | Clinical description | C A H D O R |
| Expectation of referral | A clear statement of the expectations of the person making the referral as to the management of the patient, eg, advice only, diagnosis, treatment, etc. | 0 0 0 0 0 1 |
| Patient's expectation of referral | Patient's expectations of the referral including preferences. This may include any discussions that took place, the level of shared decision-making involved, information about patient's source of advice. | 0 0 0 0 0 1 |
| ADMISSION DETAILS | | 0 1 0 1 0 0 |
| Admission method | How the patient was admitted to hospital. Eg: elective, emergency, maternity, transfer, etc. | 0 1 0 1 0 0 |
| Source of admission | Where the patient was immediately prior to admission, eg, usual place of residence, temporary place of residence, penal establishment. National code. | 0 1 0 1 0 0 |
| Patient location | This is the physical location of the patient. For inpatient, eg, hospital ward, bed, theatre. For ambulatory care, eg, health centre, clinic, resource centre, patient's home. | 0 1 1 1 1 0 |
| Responsible consultant | The name and designation of the consultant, who has overall responsibility for the patient (may not actually see the patient). | 0 1 1 0 0 0 |
| Seen by | Doctor, nurse or other healthcare professional who sees the patient. Record the most senior member of staff present (eg, ward round or where there is a junior member of staff being supervised by a more senior staff member). | 0 1 0 0 1 0 |
| Person accompanying patient | Identify others accompanying the patient, eg, relative, friend, informal carer, advocate. If the patient was not present, was an authorised representative present? | 0 1 0 0 1 0 |
| HANDOVER DETAILS | | SECTION HEADING IN HANDOVER ONLY |
| Planned patient location | If patient is changing location. | 0 0 1 0 0 0 |

(continued overleaf)

| Subheadings | Clinical description | C A H D O R |
|-------------------------------------|--|--------------------|
| Date of decision to handover | Date decision made to handover care. | 0 0 1 0 0 0 |
| New responsible consultant | The name and designation of the consultant who is accepting responsibility for the patient's inpatient care. | 0 0 1 0 0 0 |
| Date handover accepted | Date decision made to accept handover of care. | 0 0 1 0 0 0 |
| Senior clinical contact | If there is a particular requirement to call a specific person, eg, consultant, SpR (specialist registrar) or special intervention team. | 0 0 1 0 0 0 |
| OUTPATIENT DETAILS | SECTION HEADING IN OUTPATIENTS ONLY | 0 0 0 0 1 0 |
| Contact type | First contact, follow-up contact. Also scheduled, unscheduled. This is always a coded response. | 0 0 0 0 1 0 |
| Consultation method | Face to face, telephone, teleconference, etc. | 0 0 0 0 1 0 |
| Purpose of contact | Explanatory statement of the purpose of the contact. Eg unscheduled contact because patient concerned, monitoring, screening, diagnosis, assessment, pre-admission assessment, etc. | 0 0 0 0 1 0 |
| Appointment time | The time the patient was due to be seen. | 0 0 0 0 1 0 |
| Time patient seen | The time the patient was seen. | 0 0 0 0 1 0 |
| Time consultation finished | To calculate duration of consultation. | 0 0 0 0 1 0 |
| Specialty | Specialties designated by royal colleges and faculties. Eg orthopaedics, renal medicine, endocrinology, etc. | 0 1 1 0 1 0 |
| Service | Subspecialties, treatment functions or services. Eg hand surgery, back surgery, hand clinic, TIA (transient ischaemic attack) clinic, falls clinic, speech and language therapy, dialysis, family therapy, pre-admission assessment clinic, etc. | 0 1 1 0 1 0 |
| Responsible healthcare professional | The name and designation of the consultant, nurse consultant, midwife, physiotherapist, etc who has overall responsibility for the patient (may not actually see the patient). | 0 0 0 0 1 0 |
| Care professional(s) present | The name and designation of the additional individuals or team members including consultant(s), nurse consultant(s), physiotherapist(s), surgeon(s), social worker(s), etc. Eg where two or more care professionals are jointly running a session. | 0 0 0 0 1 0 |
| DISCHARGE DETAILS | SECTION HEADING IN DISCHARGE ONLY | 0 0 0 1 0 0 |
| Date of admission | Date patient admitted to hospital. | 0 1 1 1 0 0 |
| Time of admission | Time patient admitted to hospital. | 0 0 0 1 0 0 |
| Discharging consultant | The consultant responsible for the patient at time of discharge. | 0 0 0 1 0 0 |

| Subheadings | Clinical description | C A H D O R |
|----------------------------------|---|--------------------|
| Discharging specialty/department | The specialty/department responsible for the patient at the time of discharge. | 0 0 0 1 0 0 |
| Expected date of discharge | The date the patient is currently expected to be discharged from hospital. | 0 1 1 1 0 0 |
| Date of discharge | Date patient discharged from hospital. | 0 0 0 1 0 0 |
| Time of discharge | Time patient discharged from hospital. Electronic environment only. | 0 0 0 1 0 0 |
| Discharge method | The method of discharge from hospital. National codes: eg, patient discharged on clinical advice or with clinical consent; patient discharged him/herself or was discharged by a relative or advocate; patient died; stillbirth. | 0 0 0 1 0 0 |
| Discharge destination | The destination of the patient on discharge from hospital. National codes. Eg, NHS-run care home. | 0 0 0 1 0 0 |
| Discharge address | Address to which patient discharged. Only completed where this is not the usual place of residence. | 0 0 0 1 0 0 |

Relevant clinical risk factors

| Subheadings | Clinical description | C A H D O R |
|--------------------------------|---|--------------------|
| Relevant clinical risk factors | Factors that have been shown to be associated with the development of a medical condition being considered as a diagnosis/differential diagnosis. Eg being overweight, smoker, no use of sun screen, enzyme deficiency, poor sight (can impact on falls), etc. | 0 1 1 0 1 1 |
| Clinical risk assessment | Specific risk assessments required/undertaken, including thromboembolic risk assessment, etc. | 0 1 1 0 1 1 |
| Risk mitigation | Action taken to reduce the clinical risk, including thromboembolic preventative action and date actioned. | 0 1 1 0 1 1 |
| Patient at high risk | This patient is at high risk of clinical deterioration and will need an immediate response if called. | 0 0 1 0 0 0 |

Reason for contact

| Subheadings | Clinical description | C A H D O R |
|----------------------|--|--------------------|
| Reason for admission | The health problems and issues experienced by the patient resulting in their referral by a healthcare professional for hospital admission, eg, chest pain, blackout, fall, a specific procedure, investigation or treatment. | 1 1 1 1 0 0 |
| Reason for handover | A clear statement of the reason for the temporary or permanent handover of care, eg, low potassium, immediately post-op, unstable medical condition. | 1 0 1 0 0 0 |

(continued overleaf)

| Subheadings | Clinical description | C A H D O R |
|-------------------------------|---|--------------------|
| Reason for referral | A clear statement of the purpose of the person making the referral, eg, diagnosis, treatment, transfer of care due to relocation, investigation, second opinion, management of the patient (eg, palliative care), provide referrer with advice/guidance. This may include referral because of carers' concerns. | 1 0 0 0 1 1 |
| Patient's reason for referral | Patient-stated reason for referral. This may include any discussions that took place, the level of shared decision-making involved, information about patient's source of advice. This may be expressed on behalf of the patient, eg, by parent or carer. | 1 0 0 0 1 1 |

| Presenting complaints or issues | | |
|--|--|--------------------|
| Subheadings | Clinical description | C A H D O R |
| Presenting complaints or issues | The list and description of the health problems and issues experienced by the patient resulting in their attendance. These may include disease state, medical condition, response and reactions to therapies. Eg blackout, dizziness, chest pain, follow up from admission, falls, a specific procedure, investigation or treatment. | 1 1 0 0 1 1 |

| History | | |
|---|--|--------------------|
| Subheadings | Clinical description | C A H D O R |
| History of each presenting complaint or issue | Information directly related to the development and characteristics of each presenting complaint (eg, including travel history). Including if the information is given by the patient or their carer. | 0 1 0 0 1 1 |
| History since last contact | History since last attendance, discharge from hospital, etc. | 0 0 0 0 1 0 |
| Information brought by patient | Eg Patient Passport, diary data, pre-completed questionnaire, etc. | 0 1 0 0 1 0 |
| Relevant past medical, surgical and mental health history | The record of the patient's significant medical, surgical and mental health history. Including relevant previous diagnoses, problems and issues, procedures, investigations, specific anaesthesia issues, etc (will include dental and obstetric history). | 0 1 1 0 1 1 |
| Management to date | Referrals, management, investigations and treatment that have already been undertaken, including patient managing their symptoms. Including: <ul style="list-style-type: none">• Procedures conducted – procedures carried out (and the date) and procedure report. | 0 0 0 0 0 1 |

| Subheadings | Clinical description | C A H D O R |
|---------------------|--|--------------------|
| Urgency of referral | Referrer's assessment of urgency (eg, urgent/soon/routine). May include reason if other than routine. | 0 0 0 0 1 1 |

Medications and medical devices

| Subheadings | Clinical description | C A H D O R |
|------------------------------|--|--------------------|
| Medication name | May be generic name or brand name (as appropriate). | 1 1 0 1 1 1 |
| Medication form | Eg capsule, drops, tablet, lotion etc. | 1 1 0 1 1 1 |
| Route | Medication administration description (oral, IM (intramuscular), IV (intravenous), etc): may include method of administration, (eg, by infusion, via nebuliser, via NG (nasogastric) tube) and/or site of use (eg, 'to wound', 'to left eye', etc). | 1 1 0 1 1 1 |
| Dose | This is a record of the total amount of the active ingredient(s) to be given at each administration. It should include, eg, units of measurement, number of tablets, volume/concentration of liquid, number of drops, etc. | 1 1 0 1 1 1 |
| Medication frequency | Frequency of taking or administration of the therapeutic agent or medication. | 1 1 0 1 1 1 |
| Additional instructions | Allows for: <ul style="list-style-type: none">• requirements for adherence support, eg, compliance aids, prompts and packaging requirements• additional information about specific medicines, eg where specific brand required• patient requirements, eg, unable to swallow tablets. | 1 1 0 1 1 1 |
| Do not discontinue warning | To be used on a case-by-case basis if it is vital not to discontinue a medicine in a specific patient scenario. | 1 1 0 1 1 1 |
| Reason for medication | Reason for medication being prescribed, where known. | 1 1 0 1 1 1 |
| Medication recommendations | Suggestions about duration and/or review, ongoing monitoring requirements, advice on starting, discontinuing or changing medication. | 1 0 0 1 1 1 |
| Medication status | Whether or not a medication is being administered, eg, started, stopped, suspended, reinstated. Record date for each change in status. | 1 0 0 0 0 1 |
| Medication change | Where a change is made to the medication, ie one drug stopped and another started or, eg, dose, frequency or route is changed. | 1 1 0 1 1 1 |
| Reason for medication change | Reason for change in medication, eg, sub-therapeutic dose, patient intolerant. | 1 1 0 1 1 1 |
| Medicine administered | Record of administration to the patient, including self-administration. | 1 0 0 0 1 0 |

(continued overleaf)

| Subheadings | Clinical description | C A H D O R |
|-------------------------------|---|--------------------|
| Reason for non-administration | Reason why drug not administered (eg, patient refused, patient unavailable, drug not available). | 1 0 0 0 1 0 |
| Relevant previous medications | Record of relevant previous medications. | 1 1 0 0 1 1 |
| Medical devices | The record of dietary supplements, dressings and equipment that the patient is currently taking or using. | 1 1 0 1 1 1 |

| Allergies and adverse reaction | | |
|---------------------------------------|--|--------------------|
| Subheadings | Clinical description | C A H D O R |
| Causative agent | The agent such as food, drug or substances that has caused or may cause an allergy, intolerance or adverse reaction in this patient. | 1 1 1 1 1 1 |
| Description of the reaction | A description of the manifestation of the allergic or adverse reaction experienced by the patient. This may include: <ul style="list-style-type: none"> • manifestation, eg, skin rash • type of reaction (allergic, adverse, intolerance) • severity of the reaction • certainty • evidence (eg, results of investigations). | 1 1 1 1 1 1 |
| Probability of recurrence | Probability of the reaction (allergic, adverse, intolerant) occurring. | 1 1 1 1 1 1 |
| Date first experienced | When the reaction was first experienced. May be a date or partial date (eg, year) or text (eg, during childhood). | 1 1 1 1 1 1 |

| Safety alerts | | |
|----------------------|--|--------------------|
| Subheadings | Clinical description | C A H D O R |
| Risks to self | Risks the patient poses to themselves, eg, suicide, overdose, self-harm, self-neglect. | 1 1 1 1 1 1 |
| Risks to others | Risks to care professional or third party. | 1 1 1 1 1 1 |

| Legal information | | |
|------------------------------|---|--------------------|
| Subheadings | Clinical description | C A H D O R |
| Consent for treatment record | Whether consent has been obtained for the treatment. May include where record of consent is located or record of consent. | 1 1 1 1 1 1 |
| Mental capacity assessment | Whether an assessment of the mental capacity of the (adult) patient has been undertaken, if so who carried it out, when and the outcome of the assessment. Also record best interests decision if patient lacks capacity. | 1 1 1 1 1 1 |

| Subheadings | Clinical description | C A H D O R |
|--|---|--------------------|
| Advance decisions about treatment | <p>Three items:</p> <ul style="list-style-type: none"> • whether there are written documents, completed and signed when a person is legally competent, that explain a person's medical wishes in advance, allowing someone else to make treatment decisions on his or her behalf late in the disease process • location of these documents • may be copy of the document itself. | 1 1 1 1 1 1 |
| Lasting or enduring power of attorney or similar | <p>Record of individual involved in healthcare decision on behalf of the patient if the patient lacks capacity. This includes:</p> <ul style="list-style-type: none"> • whether there is a person with lasting or enduring power of attorney for personal welfare, independent mental capacity advocate (IMCA), court appointed deputy. • name and contact details for person. | 1 1 1 1 1 1 |
| Organ and tissue donation | Whether the person has given consent for organ and/or tissue donation, and if so, the location of the relevant information/documents. | 1 1 1 1 1 1 |
| Consent relating to child | <p>Consideration of age and competency, including Gillick competency.</p> <p>Record of person with parental responsibility or appointed guardian where child lacks competency.</p> | 1 1 1 1 1 1 |
| Consent to information sharing | Record of consent to information sharing, including any restrictions on sharing information with others, eg, family members, other healthcare professionals. Also use of identifiable information for research purposes. | 1 1 1 1 1 1 |
| Safeguarding issues | Any legal matters relating to safeguarding of a vulnerable child or adult, eg, child protection plan, child in need, protection of vulnerable adult. | 1 1 1 1 1 1 |

Social context

| Subheadings | Clinical description | C A H D O R |
|-----------------------|--|--------------------|
| Household composition | Eg: lives alone, lives with family, lives with partner, etc. This may be plain text. | 0 1 1 1 1 1 |
| Lives alone | Yes/no/don't know (Y/N/DK) | 0 1 1 1 1 1 |
| Lifestyle | The record of lifestyle choices made by the patient which are pertinent to his or her health and well-being, eg, the record of the patient's physical activity level, pets, hobbies, sexual habits and the current and previous use of recreational drugs. | 0 1 0 0 1 1 |
| Smoking | Latest or current smoking observation. | 0 1 0 0 1 1 |
| Alcohol intake | Latest or current alcohol consumption observation. | 0 1 0 0 1 1 |

(continued overleaf)

| Subheadings | Clinical description | C A H D O R |
|----------------------|---|--------------------|
| Occupational history | The current and/or previous relevant occupation(s) of the patient/individual. This may include educational history. | 0 1 0 1 1 1 |
| Social circumstances | The record of a patient's social background, network and personal circumstances, eg, housing, religious, ethnic and spiritual needs, social concerns and whether the patient has dependants or is a carer. May include reference to safeguarding issues that are recorded elsewhere in the record. | 0 1 0 0 1 1 |
| Services and care | The description of services and care providing support for patient's health and social well-being. | 0 1 0 0 1 1 |

Family history

| Subheadings | Clinical description | C A H D O R |
|--------------------|--|--------------------|
| Family history | The record of relevant illness in family relations deemed to be significant to the care or health of the patient, including mental illness and suicide, genetic information etc. | 1 1 0 0 1 1 |

Review of systems

| Subheadings | Clinical description | C A H D O R |
|--------------------|--|--------------------|
| Review of systems | The clinical review of systems. The record of clinical information gathered in responses to questions to the patient about general symptoms from various physiological systems, including food intake (increasing/decreasing), weight change, swallowing difficulties, mood/anxiety, etc. | 0 1 0 0 1 0 |

Patient and carer concerns

| Subheadings | Clinical description | C A H D O R |
|---|--|--------------------|
| Patient's and carer's concerns, expectations and wishes | Description of the concerns, wishes or goals of the patient, patient representative or carer. This could be the carer giving information if the patient is not competent or the parent of a young child. | 1 1 1 1 1 1 |

| Examination findings | | C A H D O R |
|-----------------------------|---|------------------------------|
| Subheadings | Clinical description | |
| Examination findings | The record of findings from clinical examination. | 0 0 0 0 0 1 |
| General appearance | The record of a clinician's 'first impression' assessment including general clinical examination finding, eg, clubbing, anaemia, jaundice, obese/malnourished/cachectic, height, weight, etc. | 0 1 0 0 1 0 |
| Vital signs | The record of essential physiological measurements, eg, heart rate, blood pressure, temperature, pulse, respiratory rate, level of consciousness. Use of National Early Warning Score (NEWS) chart where appropriate. | 0 1 0 0 1 1 |
| Mental state | Formal mental state examination or general description, eg, depression, anxiety, confusion, delirium. | 0 1 1 0 1 0 |
| Head and neck examination | The record of findings from the head and neck examination. | 0 1 0 0 1 0 |
| Oral examination | The record of findings from the oral examination. | 0 1 0 0 1 0 |
| Cardiovascular system | The record of findings from the cardiovascular system examination. | 0 1 0 0 1 0 |
| Respiratory system | The record of findings from the respiratory system examination. | 0 1 0 0 1 0 |
| Abdomen | The record of findings from the abdominal examination. | 0 1 0 0 1 0 |
| Genitourinary | The record of findings from the genitourinary examination. | 0 1 0 0 1 0 |
| Nervous system | The record of findings from the nervous system examination. | 0 1 0 0 1 0 |
| Musculoskeletal system | The record of findings from the musculoskeletal system examination. | 0 1 0 0 1 0 |
| Skin | The record of findings from examination of the skin. | 0 1 0 0 1 0 |
| Examination procedure | A procedure completed as part of the examination of the patient. Eg sigmoidoscopy, lumbar puncture, pleural tap, etc. | 0 1 0 0 1 0 |

| Assessment scales | | C A H D O R |
|--------------------------|--|------------------------------|
| Subheadings | Clinical description | |
| Assessment scales | Assessment scales used, eg, New York Heart Failure scale, Activities of Daily Living (ADL), cognitive function, mood assessment scales, developmental scales, MUST (nutrition), BPI (pain), etc. | 1 1 0 1 1 1 |

| Problems and issues | | | | | | | |
|--------------------------------------|--|----------|----------|----------|----------|----------|----------|
| Subheadings | Clinical description | C | A | H | D | O | R |
| Problems and issues | Summary of problems that require investigation or treatment. This would include significant examination findings which are likely to have relevance, yet are not a diagnosis. In mental health and psychiatry, this may be the place for formulation. | 1 | 1 | 1 | 0 | 1 | 0 |
| Diagnoses | | | | | | | |
| Subheadings | Clinical description | C | A | H | D | O | R |
| Diagnosis | Confirmed diagnosis; active diagnosis being treated. Include the stage of the disease where relevant. | 1 | 0 | 1 | 1 | 1 | 0 |
| Differential diagnosis | The determination of which one of several diseases may be producing the symptoms. | 1 | 0 | 1 | 0 | 1 | 0 |
| Episode (first, new, other, ongoing) | <ul style="list-style-type: none"> • First episode. • New episode. • Other, past or ongoing episode. | 1 | 0 | 0 | 0 | 0 | 0 |
| Date diagnosis made | The date when the diagnosis was made. | 1 | 0 | 0 | 0 | 0 | 0 |
| Date of first presentation | The date the diagnosis condition first presented. | 1 | 0 | 0 | 0 | 0 | 0 |
| Procedures | | | | | | | |
| Subheadings | Clinical description | C | A | H | D | O | R |
| Procedure | The therapeutic procedure performed. This could include site and must include laterality where applicable. | 1 | 0 | 0 | 1 | 1 | 0 |
| Complications related to procedure | Details of any intra-operative complications encountered during the procedure, arising during the patient's stay in the recovery unit or directly attributable to the procedure. The intent is to be plain text and/or images but use codes wherever possible. | 1 | 0 | 0 | 1 | 1 | 0 |
| Specific anaesthesia issues | Details of any adverse reaction to any anaesthetic agents including local anaesthesia. Problematic intubation, transfusion reaction, etc. | 1 | 0 | 0 | 1 | 1 | 0 |

Clinical summary

| Subheadings | Clinical description | C | A | H | D | O | R |
|------------------|---|---|---|---|---|---|---|
| Clinical summary | Narrative summary of the episode. Where possible, very brief. This may include interpretation of findings and results; differential diagnoses, opinion and specific action(s). Planned actions will be recorded under 'plan'. | 0 | 1 | 1 | 1 | 1 | 0 |

Investigations and results

In discharge this is called: Investigations and procedures requested

| Subheadings | Clinical description | C | A | H | D | O | R |
|--------------------------|---|---|---|---|---|---|---|
| Investigations requested | This includes a name or description of the investigation requested and the date requested. | 1 | 1 | 1 | 1 | 1 | 1 |
| Investigations results | The result of the investigation (this includes the result value, with unit of observation and reference interval where applicable and date), and plans for acting upon investigation results. | 1 | 1 | 1 | 0 | 1 | 1 |
| Procedures requested | These are the diagnostic procedures that have been requested and the date requested. | 1 | 0 | 0 | 1 | 1 | 1 |

Plan and requested actions

| Subheadings | Clinical description | C | A | H | D | O | R |
|--|---|---|---|---|---|---|---|
| Actions | Including planned investigations, procedures and treatment for a patient's identified conditions and priorities: a) person responsible – name and designation/department/ hospital/patient etc responsible for carrying out the proposed action, and where action should take place b) action – requested, planned or completed c) when action requested for – requested date, time, or period – as relevant d) suggested strategies – suggested strategies for potential problems, eg, telephone contact for advice. | 1 | 1 | 1 | 1 | 1 | 0 |
| Special monitoring required | Eg neuro-obs, O ₂ saturation etc. | 0 | 1 | 0 | 0 | 0 | 0 |
| DNACPR | Do not attempt cardiopulmonary resuscitation. This should be a record of the presence or absence of a DNACPR form. | 0 | 1 | 1 | 0 | 0 | 0 |
| Escalation plan | Who needs to be contacted in the event of significant problems or patient deterioration, eg, seniority/name/contact details of person to be called. | 0 | 0 | 1 | 0 | 0 | 0 |
| Agreed with patient or legitimate patient representative | Indicates whether the patient or legitimate representative has agreed the entire plan or individual aspects of treatment, expected outcomes, risks and alternative treatments if any (yes/no). | 1 | 1 | 1 | 1 | 1 | 0 |

(continued overleaf)

| Subheadings | Clinical description | C A H D O R |
|--|--|--------------------|
| Aims and limitations of treatment and special instructions | The current aim of treatment including limitations to treatment and communication issues, eg, not for ITU. | 0 0 1 0 0 0 |
| Next appointment details | Eg booking follow-up appointment, etc. | 0 0 0 0 1 0 |

| Outstanding issues | | |
|------------------------------|---|--------------------|
| Subheadings | Clinical description | C A H D O R |
| Tasks which must be done | Include timescales (appropriate seniority of staff for each task). | 0 0 1 0 0 0 |
| Tasks to be done if possible | Eg test review, pre-discharge documents, criteria for discharge, including who may discharge the patient. | 0 0 1 0 0 0 |

| Information given | | |
|------------------------------|--|--------------------|
| Subheadings | Clinical description | C A H D O R |
| Information and advice given | <p>This includes:</p> <ul style="list-style-type: none"> – what information – to whom it was given. <p>The oral or written information or advice given to the patient, carer, other authorised representative, care professional or other third party. May include advice about actions related to medicines or other ongoing care activities on an ‘information prescription’. State here if there are concerns about the extent to which the patient and/or carer understands the information provided about diagnosis, prognosis and treatment.</p> | 1 1 1 1 1 1 |

| Person completing record | In handover this is called: Person handing over |
|---------------------------------|--|
| Subheadings | C A H D O R |
| Name | 0 1 1 1 1 1 |
| Designation or role | 0 1 1 1 1 1 |
| Grade | 0 1 1 1 1 0 |
| Specialty | 0 1 1 1 1 0 |
| Contact details | 0 0 1 0 0 0 |
| Date completed | 0 0 0 1 1 1 |

| Person receiving handover | | C | A | H | D | O | R |
|----------------------------------|--|----------|----------|----------|----------|----------|----------|
| Subheadings | | | | | | | |
| Name | | 0 | 0 | 1 | 0 | 0 | 0 |
| Designation or role | | 0 | 0 | 1 | 0 | 0 | 0 |
| Grade | | 0 | 0 | 1 | 0 | 0 | 0 |
| Specialty | | 0 | 0 | 1 | 0 | 0 | 0 |
| Contact details | | 0 | 0 | 1 | 0 | 0 | 0 |

| Distribution list | | C | A | H | D | O | R |
|--------------------------|--|----------|----------|----------|----------|----------|----------|
| Subheadings | Clinical description | | | | | | |
| Distribution list | Other individuals to receive copies of this communication/referral letter. | 0 | 0 | 0 | 1 | 1 | 1 |

Section 2: Admission record headings

Admission record standards: standard headings for the clinical information to be recorded when a patient is admitted to hospital.

Not all headings will need to be used in all care settings or circumstances, and the order in which they appear in EHR applications, communications and letters can be agreed by system providers and end users.

| GP practice | |
|------------------------|--|
| Subheading | Clinical description |
| GP name | Where the patient or patient's representative offers the name of a GP as their usual GP. |
| GP practice details | Name, address, email, telephone number, fax of the patient's registered GP practice. |
| GP practice identifier | National code which identifies the practice. |

| Patient demographics | |
|---------------------------|---|
| Subheading | Clinical description |
| Patient name | The full name of the patient. Also patient preferred name: the name by which a patient wishes to be addressed. |
| Date of birth | The date of birth of the patient. |
| Patient sex | Sex at birth. Determines how the individual will be treated clinically. |
| Gender | As the patient wishes to portray themselves. |
| Ethnicity | The ethnicity of a person as specified by the person. |
| NHS number | The unique identifier for a patient within the NHS in England and Wales. |
| Other identifier | Country specific or local identifier, eg, Community Health Index (CHI) in Scotland. Two data items: <ul style="list-style-type: none">• type of identifier• identifier. |
| Patient address | Patient usual place of residence. |
| Patient telephone number | Telephone contact details of the person. To include, eg, mobile, work and home number if available. Two data items: <ul style="list-style-type: none">• type• number. |
| Patient email address | Email address of the patient. |
| Communication preferences | Preferred contact method, eg, sign language, letter, phone, etc. Also preferred written communication format, eg, large print, braille. |

| Subheading | Clinical description |
|-------------------|---|
| Relevant contacts | Eg next of kin, main informal carer, emergency contact. Including: <ul style="list-style-type: none"> • full name • relationship (eg, next of kin) • role (eg, court appointed deputy) • contact details. |

| Special requirements | |
|----------------------|--|
| Subheading | Clinical description |
| Special requirements | Eg level of language (literacy); preferred language (interpreter required)/ambulance required/other transport arrangements required/any other special requirements. Includes: <ul style="list-style-type: none"> • preferred language • interpreter required • advocate required • transport required, etc. |

| Participation in research | |
|---------------------------|--|
| Subheading | Clinical description |
| Participation in research | This is to flag participation in a clinical trial. This may include whether participation in a trial has been offered, refused or accepted, the name of the trial, drug/intervention tested, enrolment date, duration of treatment and follow up, and contact number for adverse events or queries. |

| Admission details | |
|---------------------|---|
| Subheading | Clinical description |
| Date of admission | Date patient admitted to hospital. |
| Admission method | How the patient was admitted to hospital. Eg elective, emergency, maternity, transfer, etc. |
| Referrer details | Name, designation, organisation and contact details of referrer. If not an individual, this could be, eg, GP surgery, department, specialty, subspecialty, educational institution, mental health etc. Also needs to include self-referral. Includes: <ul style="list-style-type: none"> • name • role • specialty, department or team • organisation • contact details, eg, email, fax, telephone. |
| Source of admission | National code. Where the patient was immediately prior to admission, eg, usual place of residence, temporary place of residence, penal establishment. |

(continued overleaf)

| Subheading | Clinical description |
|-----------------------------|---|
| Responsible consultant | The name and designation of the consultant, who has overall responsibility for the patient (may not actually see the patient). |
| Specialty | Specialties designated by Royal Colleges and Faculties. Eg orthopaedics, renal medicine, endocrinology, etc. |
| Service | Subspecialties, treatment functions or services. Eg hand surgery, back surgery, hand clinic, TIA clinic, falls clinic, speech and language therapy, dialysis, family therapy, pre-admission assessment clinic, etc. |
| Seen by | Doctor, nurse or other healthcare professional who sees the patient. Record the most senior member of staff present (eg, ward round or where there is a junior member of staff being supervised by a more senior staff member). Includes: <ul style="list-style-type: none">• name• role• telephone number. |
| Patient location | This is the physical location of the patient. For inpatient, eg, hospital ward, bed, theatre. For ambulatory care, eg, health centre, clinic, resource centre, patient's home. |
| Person accompanying patient | Identify others accompanying the patient, eg, relative, friend, informal carer, advocate. If the patient was not present was an authorised representative present? Includes: <ul style="list-style-type: none">• name• relationship (spouse, etc)• role (patient advocate, etc). |

History

| Subheading | Clinical description |
|---|--|
| Reason for admission | The health problems and issues experienced by the patient resulting in their referral by a healthcare professional for hospital admission, eg, chest pain, blackout, fall, a specific procedure, investigation or treatment. |
| Presenting complaints or issues | The list and description of the health problems and issues experienced by the patient resulting in their attendance. These may include disease state, medical condition, response and reactions to therapies. Eg blackout, dizziness, chest pain, follow up from admission, falls, a specific procedure, investigation or treatment. |
| History of each presenting complaint or issue | Information directly related to the development and characteristics of each presenting complaint (eg, including travel history). Including if the information is given by the patient or their carer. |
| Information brought by patient | Eg Patient Passport, example diary data, pre-completed questionnaire, etc. |
| Relevant past medical, surgical and mental health history | The record of the patient's significant medical, surgical and mental health history. Including relevant previous diagnoses, problems and issues, procedures, investigations, specific anaesthesia issues, etc (will include dental and obstetric history). |

| Medications and medical devices | |
|--|--|
| Subheading | Clinical description |
| Medication name | May be generic name or brand name (as appropriate). |
| Medication form | Eg capsule, drops, tablet, lotion etc. |
| Route | Medication administration description (oral, IM, IV, etc): may include method of administration (eg, by infusion, via nebuliser, via NG tube) and/or site of use (eg, 'to wound', 'to left eye', etc). |
| Dose | This is a record of the total amount of the active ingredient(s) to be given at each administration. It should include, eg, units of measurement, number of tablets, volume/concentration of liquid, number of drops, etc. |
| Medication frequency | Frequency of taking or administration of the therapeutic agent or medication. |
| Additional instructions | Allows for: <ul style="list-style-type: none"> • requirements for adherence support, eg, compliance aids, prompts and packaging requirements • additional information about specific medicines, eg where specific brand required • patient requirements, eg, unable to swallow tablets. |
| Do not discontinue warning | To be used on a case-by-case basis if it is vital not to discontinue a medicine in a specific patient scenario. |
| Reason for medication | Reason for medication being prescribed, where known. |
| Medication recommendations | Suggestions about duration and/or review, ongoing monitoring requirements, advice on starting, discontinuing or changing medication. |
| Medication status | Whether or not a medication is being administered, eg, started, stopped, suspended, reinstated. Record date for each change in status. |
| Medication change | Where a change is made to the medication, ie one drug stopped and another started or, eg, dose, frequency or route is changed. |
| Reason for medication change | Reason for change in medication, eg, sub-therapeutic dose, patient intolerant. |
| Medicine administered | Record of administration to the patient, including self-administration. |
| Reason for non-administration | Reason why drug not administered (eg, patient refused, patient unavailable, drug not available). |
| Relevant previous medications | Record of relevant previous medications |
| Medical devices | The record of dietary supplements, dressings and equipment that the patient is currently taking or using. |

| Allergies and adverse reaction | |
|---------------------------------------|--|
| Subheading | Clinical description |
| Causative agent | The agent such as food, drug or substances that has caused or may cause an allergy, intolerance or adverse reaction in this patient. |
| Description of the reaction | A description of the manifestation of the allergic or adverse reaction experienced by the patient. This may include: <ul style="list-style-type: none"> • manifestation, eg, skin rash • type of reaction (allergic, adverse, intolerance) • severity of the reaction • certainty • evidence (eg, results of investigations). |
| Probability of recurrence | Probability of the reaction (allergic, adverse, intolerant) occurring. |
| Date first experienced | When the reaction was first experienced. May be a date or partial date (eg, year) or text (eg, during childhood). |

| Safety alerts | |
|----------------------|--|
| Subheading | Clinical description |
| Risks to self | Risks the patient poses to themselves, eg, suicide, overdose, self-harm, self-neglect. |
| Risks to others | Risks to care professional or third party. |

| Family history | |
|-----------------------|--|
| Subheading | Clinical description |
| Family history | The record of relevant illness in family relations deemed to be significant to the care or health of the patient, including mental illness and suicide, genetic information etc. |

| Social context | |
|-----------------------|--|
| Subheading | Clinical description |
| Household composition | Eg: lives alone, lives with family, lives with partner, etc. This may be plain text. |
| Lives alone | Yes/no/don't know (Y/N/DK). |
| Lifestyle | The record of lifestyle choices made by the patient which are pertinent to his or her health and well-being, eg, the record of the patient's physical activity level, pets, hobbies, sexual habits and the current and previous use of recreational drugs. |
| Smoking | Latest or current smoking observation. |
| Alcohol intake | Latest or current alcohol consumption observation. |

| Subheading | Clinical description |
|----------------------|---|
| Occupational history | The current and/or previous relevant occupation(s) of the patient/individual. This may include educational history. |
| Social circumstances | The record of a patient's social background, network and personal circumstances, eg, housing, religious, ethnic and spiritual needs, social concerns and whether the patient has dependants or is a carer. May include reference to safeguarding issues that are recorded elsewhere in the record. |
| Services and care | The description of services and care providing support for patient's health and social well-being. |

Patient and carer concerns

| Subheading | Clinical description |
|---|---|
| Patient's and carer's concerns, expectations and wishes | Description of the concerns, wishes or goals of the patient, patient representative or carer. This could be the carer giving information if the patient is not competent, or the parent of a young child. |

Legal information

| Subheading | Clinical description |
|--|--|
| Consent for treatment record | Whether consent has been obtained for the treatment. May include where record of consent is located or record of consent. |
| Mental capacity assessment | Whether an assessment of the mental capacity of the (adult) patient has been undertaken, if so who carried it out, when and the outcome of the assessment. Also record best interests decision if patient lacks capacity. |
| Advance decisions about treatment | Three items: <ul style="list-style-type: none"> • whether there are written documents, completed and signed when a person is legally competent, that explain a person's medical wishes in advance, allowing someone else to make treatment decisions on his or her behalf late in the disease process • location of these documents • may be copy of the document itself. |
| Lasting or enduring power of attorney or similar | Record of individual involved in healthcare decision on behalf of the patient if the patient lacks capacity. This includes: <ul style="list-style-type: none"> • whether there is a person with lasting or enduring power of attorney, independent mental capacity advocate (IMCA), court appointed deputy. • name and contact details for person. |
| Organ and tissue donation | Two data items: <ul style="list-style-type: none"> – has the person given consent for organ and/or tissue donation (yes/no)? – the location of the relevant information/documents. |

(continued overleaf)

| Subheading | Clinical description |
|--------------------------------|--|
| Consent relating to child | Consideration of age and competency, including Gillick competency. Record of person with parental responsibility or appointed guardian where child lacks competency. |
| Consent to information sharing | Record of consent to information sharing, including any restrictions on sharing information with others, eg, family members, other healthcare professionals. Also use of identifiable information for research purposes. |
| Safeguarding issues | Any legal matters relating to safeguarding of a vulnerable child or adult, eg, child protection plan, child in need, protection of vulnerable adult. |

| Review of systems | |
|--------------------------|--|
| Subheading | Clinical description |
| Review of systems | The clinical review of systems. The record of clinical information gathered in responses to questions to the patient about general symptoms from various physiological systems, including food intake (increasing/decreasing), weight change, swallowing difficulties, mood/anxiety, etc. |

| Examination findings | |
|-----------------------------|---|
| Subheading | Clinical description |
| General appearance | The record of a clinician's 'first impression' assessment including general clinical examination finding, eg, clubbing, anaemia, jaundice, obese/malnourished/cachectic, height, weight, etc. |
| Vital signs | The record of essential physiological measurements, eg, heart rate, blood pressure, temperature, pulse, respiratory rate, level of consciousness. Use of National Early Warning Score (NEWS) chart where appropriate. |
| Mental state | Formal mental state examination or general description, eg, depression, anxiety, confusion, delirium. |
| Head and neck examination | The record of findings from the head and neck examination. |
| Oral examination | The record of findings from the oral examination. |
| Cardiovascular system | The record of findings from the cardiovascular system examination. |
| Respiratory system | The record of findings from the respiratory system examination. |
| Abdomen | The record of findings from the abdominal examination. |
| Genitourinary | The record of findings from the genitourinary examination. |
| Nervous system | The record of findings from the nervous system examination. |
| Musculoskeletal system | The record of findings from the musculoskeletal system examination. |
| Skin | The record of findings from examination of the skin. |
| Examination procedure | A procedure completed as part of the examination of the patient. Eg sigmoidoscopy, lumbar puncture, pleural tap, etc. |

Assessment scales

| Subheading | Clinical description |
|-------------------|--|
| Assessment scales | Assessment scales used, eg, New York Heart Failure scale, Activities of Daily Living (ADL), cognitive function, mood assessment scales, developmental scales, MUST (nutrition), BPI (pain), etc. |

Problems and issues

| Subheading | Clinical description |
|---------------------|---|
| Problems and issues | Summary of problems that require investigation or treatment. This would include significant examination findings which are likely to have relevance and yet are not a diagnosis. In mental health and psychiatry, this may be the place for formulation. |

Relevant clinical risk factors

| Subheading | Clinical description |
|--------------------------------|---|
| Relevant clinical risk factors | Factors that have been shown to be associated with the development of a medical condition being considered as a diagnosis/differential diagnosis. Eg being overweight, smoker, no use of sun screen, enzyme deficiency, poor sight (can impact on falls), etc. |
| Clinical risk assessment | Specific risk assessments required/undertaken, including thromboembolic risk assessment, etc. |
| Risk mitigation | Action taken to reduce the clinical risk, including thromboembolic preventative action and date actioned. |

Clinical summary

| Subheading | Clinical description |
|----------------------------|---|
| Clinical summary | Narrative summary of the episode. Where possible, very brief. This may include interpretation of findings and results; differential diagnoses, opinion and specific action(s). Planned actions will be recorded under 'plan'. |
| Expected date of discharge | The date the patient is currently expected to be discharged from hospital. |

| Investigations and results | |
|--|--|
| Subheading | Clinical description |
| Investigations requested | This includes a name or description of the investigation requested and the date requested. |
| Investigations results | The result of the investigation (this includes the result value, with unit of observation and reference interval where applicable and date), and plans for acting upon investigation results. |
| Plan and requested actions | |
| Subheading | Clinical description |
| Actions | <p>Including planned investigations, procedures and treatment for a patient's identified conditions and priorities:</p> <ul style="list-style-type: none"> a) person responsible – name and designation/department/hospital/patient/etc responsible for carrying out the proposed action, and where action should take place b) action – requested, planned or completed c) when action requested for – requested date, time, or period – as relevant d) suggested strategies – suggested strategies for potential problems, eg, telephone contact for advice. |
| Special monitoring required | Eg neuro-obs, O ₂ saturation etc. |
| DNACPR | Do not attempt cardiopulmonary resuscitation. This should be a record of the presence or absence of a DNACPR form. |
| Agreed with patient or legitimate patient representative | Indicates whether the patient or legitimate representative has agreed the entire plan or individual aspects of treatment, expected outcomes, risks and alternative treatments if any (yes/no). |
| Information given | |
| Subheading | Clinical description |
| Information and advice given | <p>This includes:</p> <ul style="list-style-type: none"> – what information – to whom it was given. <p>The oral or written information or advice given to the patient, carer, other authorised representative, care professional or other third party. May include advice about actions related to medicines or other ongoing care activities on an 'information prescription'.</p> <p>State here if there are concerns about the extent to which the patient and/or carer understands the information provided about diagnosis, prognosis and treatment.</p> |

Person completing record

Subheading

Name

Designation or role

Grade

Specialty

Section 3: Handover record headings

Handover record standards: standard headings for the clinical information that should be recorded and used for handover of patient care from one professional or team to another, including hospital at night, weekend and consultant team to consultant team.

Not all headings will need to be used in all care settings or circumstances, and the order in which they appear in EHR applications, communications and letters can be agreed by system providers and end users.

| GP practice | |
|---------------------------|---|
| Subheading | Clinical description |
| GP name | Where the patient or patient's representative offers the name of a GP as their usual GP. |
| GP practice details | Name, address, email, telephone number, fax of the patient's registered GP practice. |
| GP practice identifier | National code which identifies the practice. |
| Patient demographics | |
| Subheading | Clinical description |
| Patient name | The full name of the patient. Also patient preferred name: the name by which a patient wishes to be addressed. |
| Date of birth | The date of birth of the patient. |
| Patient sex | Sex at birth. Determines how the individual will be treated clinically. |
| Gender | As the patient wishes to portray themselves. |
| Ethnicity | The ethnicity of a person as specified by the person. |
| NHS number | The unique identifier for a patient within the NHS in England and Wales. |
| Other identifier | Country specific or local identifier, eg, Community Health Index (CHI) in Scotland. Two data items: <ul style="list-style-type: none">• type of identifier• identifier. |
| Patient address | Patient's usual place of residence. |
| Patient telephone number | Telephone contact details of the person. To include, eg, mobile, work and home number if available. Two data items: <ul style="list-style-type: none">• type• number. |
| Patient email address | Email address of the patient. |
| Communication preferences | Preferred contact method, eg, sign language, letter, phone, etc. Also preferred written communication format, eg, large print, braille. |

| Subheading | Clinical description |
|-------------------|--|
| Relevant contacts | Eg next of kin, main informal carer, emergency contact. Including: <ul style="list-style-type: none">• full name• relationship (eg, next of kin)• role (eg, court appointed deputy)• contact details. |

Social context

| Subheading | Clinical description |
|-----------------------|--|
| Household composition | Eg: lives alone, lives with family, lives with partner, etc. This may be plain text. |
| Lives alone | Yes/no/don't know (Y/N/DK). |

Special requirements

| Subheading | Clinical description |
|----------------------|---|
| Special requirements | Eg level of language (literacy); preferred language (interpreter required)/ambulance required/other transport arrangements required/any other special requirements. Includes: <ul style="list-style-type: none">• preferred language• interpreter required• advocate required• transport required, etc. |

Participation in research

| Subheading | Clinical description |
|---------------------------|--|
| Participation in research | This is to flag participation in a clinical trial. This may include whether participation in a trial has been offered, refused or accepted, the name of the trial, drug/intervention tested, enrolment date, duration of treatment and follow up, and contact number for adverse events or queries. |

Handover details

| Subheading | Clinical description |
|----------------------------|--|
| Patient location | This is the physical location of the patient. For inpatient, eg, hospital ward, bed, theatre. For ambulatory care, eg, health centre, clinic, resource centre, patient's home. |
| Planned patient location | If patient is changing location. |
| Date of admission | Date patient admitted to hospital. |
| Expected date of discharge | The date the patient is currently expected to be discharged from hospital. |

(continued overleaf)

| Subheading | Clinical description |
|------------------------------|---|
| Responsible consultant | The name and designation of the consultant, who has overall responsibility for the patient (may not actually see the patient). |
| Specialty | Specialties designated by royal colleges and faculties. Eg orthopaedics, renal medicine, endocrinology, etc. |
| Service | Subspecialties, treatment functions or services. Eg hand surgery, back surgery, hand clinic, TIA clinic, falls clinic, speech and language therapy, dialysis, family therapy, pre-admission assessment clinic, etc. |
| Date of decision to handover | Date decision made to handover care. |
| New responsible consultant | The name and designation of the consultant who is accepting responsibility for the patient's inpatient care. |
| Date handover accepted | Date decision made to accept handover of care. |
| Reason for handover | A clear statement of the reason for the temporary or permanent handover of care, eg, low potassium, immediately post-op, unstable medical condition. |
| Senior clinical contact | If there is a particular requirement to call a specific person, eg, consultant, SpR or special intervention team. |

| Clinical details | |
|---|--|
| Subheading | Clinical description |
| Reason for admission | The health problems and issues experienced by the patient resulting in their referral by a healthcare professional for hospital admission, eg, chest pain, blackout, fall, a specific procedure, investigation or treatment. |
| Clinical summary | Narrative summary of the episode. Where possible, very brief. This may include interpretation of findings and results; differential diagnoses, opinion and specific action(s). Planned actions will be recorded under 'plan'. |
| Mental state | Formal mental state examination or general description, eg, depression, anxiety, confusion, delirium. |
| Relevant past medical, surgical and mental health history | The record of the patient's significant medical, surgical and mental health history. Including relevant previous diagnoses, problems and issues, procedures, investigations, specific anaesthesia issues, etc (will include dental and obstetric history). |

Investigations and results

| Subheading | Clinical description |
|--------------------------|---|
| Investigations requested | This includes a name or description of the investigation requested and the date requested. |
| Investigations results | The result of the investigation (this includes the result value, with unit of observation and reference interval where applicable and date), and plans for acting upon investigation results. |

Diagnoses

| Subheading | Clinical description |
|------------------------|--|
| Diagnosis | Confirmed diagnosis; active diagnosis being treated. Include the stage of the disease where relevant. |
| Differential diagnosis | The determination of which one of several diseases may be producing the symptoms. |

Problems and issues

| Subheading | Clinical description |
|---------------------|---|
| Problems and issues | Summary of problems that require investigation or treatment. This would include significant examination findings which are likely to have relevance and yet are not a diagnosis. In mental health and psychiatry, this may be the place for formulation. |

Legal information

| Subheading | Clinical description |
|-----------------------------------|--|
| Consent for treatment record | Whether consent has been obtained for the treatment. May include where record of consent is located or record of consent. |
| Mental capacity assessment | Whether an assessment of the mental capacity of the (adult) patient has been undertaken, if so who carried it out, when and the outcome of the assessment. Also record best interests decision if patient lacks capacity. |
| Advance decisions about treatment | Three items: <ul style="list-style-type: none"> • whether there are written documents, completed and signed when a person is legally competent, that explain a person's medical wishes in advance, allowing someone else to make treatment decisions on his or her behalf late in the disease process • location of these documents • may be copy of the document itself. |

(continued overleaf)

| Subheading | Clinical description |
|--|--|
| Lasting or enduring power of attorney or similar | Record of individual involved in healthcare decision on behalf of the patient if the patient lacks capacity. This includes: <ul style="list-style-type: none"> • whether there is a person with lasting or enduring power of attorney, independent mental capacity advocate (IMCA), court appointed deputy. • name and contact details for person. |
| Organ and tissue donation | Two data items: <ul style="list-style-type: none"> – has the person given consent for organ and/or tissue donation (yes/no)? – The location of the relevant information/documents. |
| Consent relating to child | Consideration of age and competency, including Gillick competency. Record of person with parental responsibility or appointed guardian where child lacks competency. |
| Consent to information sharing | Record of consent to information sharing, including any restrictions on sharing information with others, eg, family members, other healthcare professionals. Also use of identifiable information for research purposes. |
| Safeguarding issues | Any legal matters relating to safeguarding of a vulnerable child or adult, eg, child protection plan, child in need, protection of vulnerable adult. |

Relevant clinical risk factors

| Subheading | Clinical description |
|--------------------------------|--|
| Patient at high risk | This patient is at high risk of clinical deterioration and will need an immediate response if called. |
| Relevant clinical risk factors | Factors that have been shown to be associated with the development of a medical condition being considered as a diagnosis/ differential diagnosis. Eg being overweight, smoker, no use of sun screen, enzyme deficiency, poor sight (can impact on falls), etc. |
| Clinical risk assessment | Specific risk assessments required/undertaken, including thromboembolic risk assessment, etc. |
| Risk mitigation | Action taken to reduce the clinical risk, including thromboembolic preventative action and date actioned. |

Allergies and adverse reaction

| Subheading | Clinical description |
|-----------------------------|--|
| Causative agent | The agent such as food, drug or substances that has caused or may cause an allergy, intolerance or adverse reaction in this patient. |
| Description of the reaction | A description of the manifestation of the allergic or adverse reaction experienced by the patient. This may include: <ul style="list-style-type: none"> • manifestation, eg, skin rash • type of reaction (allergic, adverse, intolerance) • severity of the reaction • certainty • evidence (eg, results of investigations). |

| Subheading | Clinical description |
|---------------------------|---|
| Probability of recurrence | Probability of the reaction (allergic, adverse, intolerant) occurring. |
| Date first experienced | When the reaction was first experienced. May be a date or partial date (eg, year) or text (eg, during childhood). |

Safety alerts

| Subheading | Clinical description |
|-----------------|--|
| Risks to self | Risks the patient poses to themself, eg, suicide, overdose, self-harm, self-neglect. |
| Risks to others | Risks to care professional or third party. |

Plan and requested actions

| Subheading | Clinical description |
|--|--|
| Actions | <p>Including planned investigations, procedures and treatment for a patient's identified conditions and priorities:</p> <ul style="list-style-type: none"> a) person responsible – name and designation/department/hospital/patient/etc responsible for carrying out the proposed action, and where action should take place b) action – requested, planned or completed c) when action requested for – requested date, time, or period – as relevant d) suggested strategies – suggested strategies for potential problems, eg, telephone contact for advice. |
| Aims and limitations of treatment and special instructions | The current aim of treatment including limitations to treatment and communication issues, eg, not for ITU. |
| Escalation plan | Who needs to be contacted in the event of significant problems or patient deterioration include, eg, seniority/name/contact details of person to be called. |
| Agreed with patient or legitimate patient representative | Indicates whether the patient or legitimate representative has agreed the entire plan or individual aspects of treatment, expected outcomes, risks and alternative treatments if any (yes/no). |
| DNACPR | Do not attempt cardiopulmonary resuscitation. This should be a record of the presence or absence of a DNACPR form. |

Outstanding issues

| Subheading | Clinical description |
|------------------------------|---|
| Tasks which must be done | Include timescales (appropriate seniority of staff for each task). |
| Tasks to be done if possible | Eg test review, pre-discharge documents, criteria for discharge, including who may discharge the patient. |

| Patient and carer concerns | |
|---|---|
| Subheading | Clinical description |
| Patient's and carer's concerns, expectations and wishes | Description of the concerns, wishes or goals of the patient, patient representative or carer. This could be the carer giving information if the patient is not competent or the parent of a young child. |
| Information given | |
| Subheading | Clinical description |
| Information and advice given | <p>This includes:</p> <ul style="list-style-type: none"> – what information – to whom it was given. <p>The oral or written information or advice given to the patient, carer, other authorised representative, care professional or other third party. May include advice about actions related to medicines or other ongoing care activities on an 'information prescription'.</p> <p>State here if there are concerns about the extent to which the patient and/or carer understands the information provided about diagnosis, prognosis and treatment.</p> |
| Person handing over | |
| Subheading | |
| Name | |
| Designation or role | |
| Grade | |
| Specialty | |
| Contact details | |
| Person receiving handover | |
| Subheading | |
| Name | |
| Designation or role | |
| Grade | |
| Specialty | |
| Contact details | |

Section 4: Discharge record headings

Discharge record standards: standard headings for the clinical information that should be recorded in the discharge record and included in the discharge summary communication from hospital to GP and patient.

Not all headings will need to be used in all care settings or circumstances, and the order in which they appear in EHR applications, communications and letters can be agreed by system providers and end users.

| GP practice | |
|------------------------|--|
| Subheading | Clinical description |
| GP name | Where the patient or patient's representative offers the name of a GP as their usual GP. |
| GP practice details | Name, address, email, telephone number, fax of the patient's registered GP practice. |
| GP practice identifier | National code which identifies the practice. |

| Referral details | |
|------------------|---|
| Subheading | Clinical description |
| Referrer details | Name, designation, organisation and contact details of referrer. If not an individual, this could be, eg, GP surgery, department, specialty, subspecialty, educational institution, mental health etc. Also needs to include self-referral. |

| Patient demographics | |
|----------------------|---|
| Subheading | Clinical description |
| Patient name | The full name of the patient. Also patient preferred name: the name by which a patient wishes to be addressed. |
| Date of birth | The date of birth of the patient. |
| Patient sex | Sex at birth. Determines how the individual will be treated clinically. |
| Gender | As the patient wishes to portray themselves. |
| Ethnicity | The ethnicity of a person as specified by the person. |
| NHS number | The unique identifier for a patient within the NHS in England and Wales. |
| Other identifier | Country specific or local identifier, eg, Community Health Index (CHI) in Scotland. Two data items: <ul style="list-style-type: none">• type of identifier• identifier. |
| Patient address | Patient usual place of residence. |

(continued overleaf)

| Subheading | Clinical description |
|---------------------------|--|
| Patient telephone number | Telephone contact details of the person. To include, eg, mobile, work and home number if available. Two data items: <ul style="list-style-type: none">• type• number. |
| Patient email address | Email address of the patient. |
| Communication preferences | Preferred contact method, eg, sign language, letter, phone, etc. Also preferred written communication format, eg, large print, braille. |
| Relevant contacts | Eg next of kin, main informal carer, emergency contact. Including: <ul style="list-style-type: none">• full name• relationship (eg, next of kin)• role (eg, court appointed deputy)• contact details. |

Social context

| Subheading | Clinical description |
|-----------------------|---|
| Household composition | Eg: lives alone, lives with family, lives with partner, etc. This may be plain text. |
| Lives alone | Yes/no/don't know (Y/N/DK). |
| Occupational history | The current and/or previous relevant occupation(s) of the patient/individual. This may include educational history. |

Special requirements

| Subheading | Clinical description |
|----------------------|---|
| Special requirements | Eg level of language (literacy); preferred language (interpreter required)/ambulance required/other transport arrangements required/any other special requirements. Includes: <ul style="list-style-type: none">• preferred language• interpreter required• advocate required• transport required, etc. |

Participation in research

| Subheading | Clinical description |
|---------------------------|--|
| Participation in research | This is to flag participation in a clinical trial. This may include whether participation in a trial has been offered, refused or accepted, the name of the trial, drug/intervention tested, enrolment date, duration of treatment and follow up, and contact number for adverse events or queries. |

Admission details

| Subheading | Clinical description |
|---------------------|--|
| Admission method | How the patient was admitted to hospital. Eg: elective, emergency, maternity, transfer, etc. |
| Source of admission | National code. Where the patient was immediately prior to admission, eg, usual place of residence, temporary place of residence, penal establishment. |
| Patient location | This is the physical location of the patient. For inpatient, eg, hospital ward, bed, theatre. For ambulatory care, eg, health centre, clinic, resource centre, patient's home. |
| Date of admission | Date patient admitted to hospital. |
| Time of admission | Time patient admitted to hospital. |

Discharge details

| Subheading | Clinical description |
|----------------------------------|---|
| Discharging consultant | The consultant responsible for the patient at time of discharge. |
| Discharging specialty/department | The specialty/department responsible for the patient at the time of discharge. |
| Expected date of discharge | The date the patient is currently expected to be discharged from hospital. |
| Date of discharge | |
| Time of discharge | Electronic environment only. |
| Discharge method | The method of discharge from hospital. National codes: eg, patient discharged on clinical advice or with clinical consent; patient discharged him/herself or was discharged by a relative or advocate, patient died, stillbirth. |
| Discharge destination | The destination of the patient on discharge from hospital. National codes. Eg NHS-run care home. |
| Discharge address | Address to which patient discharged. Only completed where this is not the usual place of residence. |

Clinical details

| Subheading | Clinical description |
|----------------------|--|
| Reason for admission | The health problems and issues experienced by the patient resulting in their referral by a healthcare professional for hospital admission, eg, chest pain, blackout, fall, a specific procedure, investigation or treatment. |

Diagnoses

| Subheading | Clinical description |
|------------|--|
| Diagnosis | Confirmed diagnosis; active diagnosis being treated. Include the stage of the disease where relevant. |

Procedures

| Subheading | Clinical description |
|------------------------------------|--|
| Procedure | The therapeutic procedure performed. This could include site and must include laterality where applicable. |
| Complications related to procedure | Details of any intra-operative complications encountered during the procedure, arising during the patient's stay in the recovery unit or directly attributable to the procedure. The intent is to be plain text and/or images but use codes wherever possible. |
| Specific anaesthesia issues | Details of any adverse reaction to any anaesthetic agents including local anaesthesia. Problematic intubation, transfusion reaction, etc. |

Clinical summary

| Subheading | Clinical description |
|-----------------------|---|
| Clinical summary | Narrative summary of the episode. Where possible, very brief. This may include interpretation of findings and results; differential diagnoses, opinion and specific action(s). Planned actions will be recorded under 'plan'. |
| Investigation results | The result of the investigation (this includes the result value, with unit of observation and reference interval where applicable and date), and plans for acting upon investigation results. |

Assessment scales

| Subheading | Clinical description |
|-------------------|--|
| Assessment scales | Assessment scales used, eg, New York Heart Failure scale, Activities of Daily Living (ADL), cognitive function, mood assessment scales, developmental scales, MUST (nutrition), BPI (pain), etc. |

Legal information

| Subheading | Clinical description |
|--|--|
| Consent for treatment record | Whether consent has been obtained for the treatment. May include where record of consent is located or record of consent. |
| Mental capacity assessment | Whether an assessment of the mental capacity of the (adult) patient has been undertaken, if so who carried it out, when and the outcome of the assessment. Also record best interests decision if patient lacks capacity. |
| Advance decisions about treatment | Three items: <ul style="list-style-type: none"> • whether there are written documents, completed and signed when a person is legally competent, that explain a person's medical wishes in advance, allowing someone else to make treatment decisions on his or her behalf late in the disease process • location of these documents • may be copy of the document itself. |
| Lasting or enduring power of attorney or similar | Record of individual involved in healthcare decision on behalf of the patient if the patient lacks capacity. This includes: <ul style="list-style-type: none"> • whether there is a person with lasting or enduring power of attorney, Independent Mental Capacity Advocate (IMCA), court appointed deputy • name and contact details for person. |
| Organ and tissue donation | Two data items: <ul style="list-style-type: none"> – has the person given consent for organ and/or tissue donation (yes/no)? – the location of the relevant information/documents. |
| Consent relating to child | Consideration of age and competency, including Gillick competency. Record of person with parental responsibility or appointed guardian where child lacks competency. |
| Consent to information sharing | Record of consent to information sharing, including any restrictions on sharing information with others, eg, family members, other healthcare professionals. Also use of identifiable information for research purposes. |
| Safeguarding issues | Any legal matters relating to safeguarding of a vulnerable child or adult, eg, child protection plan, child in need, protection of vulnerable adult. |

Safety alerts

| Subheading | Clinical description |
|-----------------|--|
| Risks to self | Risks the patient poses to themself, eg, suicide, overdose, self-harm, self-neglect. |
| Risks to others | Risks to care professional or third party. |

| Medications and medical devices | |
|--|--|
| Subheading | Clinical description |
| Medication name | May be generic name or brand name (as appropriate). |
| Medication form | Eg capsule, drops, tablet, lotion etc. |
| Route | Medication administration description (oral, IM, IV, etc): may include method of administration (eg, by infusion, via nebuliser, via NG tube) and/or site of use (eg, 'to wound', 'to left eye', etc). |
| Dose | <p>This is a record of the total amount of the active ingredient(s) to be given at each administration.</p> <p>It should include, eg, units of measurement, number of tablets, volume/concentration of liquid, number of drops, etc.</p> |
| Medication frequency | Frequency of taking or administration of the therapeutic agent or medication. |
| Additional instructions | <p>Allows for:</p> <ul style="list-style-type: none"> • requirements for adherence support, eg, compliance aids, prompts and packaging requirements • additional information about specific medicines, eg, where specific brand required • patient requirements, eg, unable to swallow tablets. |
| Do not discontinue warning | To be used on a case-by-case basis if it is vital not to discontinue a medicine in a specific patient scenario. |
| Reason for medication | Reason for medication being prescribed, where known. |
| Medication recommendations | Suggestions about duration and/or review, ongoing monitoring requirements, advice on starting, discontinuing or changing medication. |
| Medication change | Where a change is made to the medication, ie, one drug stopped and another started, or, eg, dose, frequency or route is changed. |
| Reason for medication change | Reason for change in medication, eg, sub-therapeutic dose, patient intolerant. |
| Medical devices | The record of dietary supplements, dressings and equipment that the patient is currently taking or using. |

| Allergies and adverse reaction | |
|---------------------------------------|---|
| Subheading | Clinical description |
| Causative agent | The agent such as food, drug or substances that has caused or may cause an allergy, intolerance or adverse reaction in this patient. |
| Description of the reaction | <p>A description of the manifestation of the allergic or adverse reaction experienced by the patient. This may include:</p> <ul style="list-style-type: none"> • manifestation, eg, skin rash • type of reaction (allergic, adverse, intolerance) • severity of the reaction • certainty • evidence (eg, results of investigations). |

| Subheading | Clinical description |
|---------------------------|---|
| Probability of recurrence | Probability of the reaction (allergic, adverse, intolerant) occurring. |
| Date first experienced | When the reaction was first experienced. May be a date or partial date (eg, year) or text (eg, during childhood). |

| Investigations and procedures requested | |
|--|---|
| Subheading | Clinical description |
| Investigations requested | This includes a name or description of the investigation requested and the date requested. |
| Procedures requested | These are the diagnostic procedures that have actually been requested (and the date requested). |

| Patient and carer concerns | |
|---|---|
| Subheading | Clinical description |
| Patient's and carer's concerns, expectations and wishes | Description of the concerns, wishes or goals of the patient, patient representative or carer. This could be the carer giving information if the patient is not competent, or the parent of a young child. |

| Information given | |
|------------------------------|---|
| Subheading | Clinical description |
| Information and advice given | <p>This includes:</p> <ul style="list-style-type: none"> – what information – to whom it was given. <p>The oral or written information or advice given to the patient, carer, other authorised representative, care professional or other third party. May include advice about actions related to medicines or other ongoing care activities on an 'information prescription'.</p> <p>State here if there are concerns about the extent to which the patient and/or carer understands the information provided about diagnosis, prognosis and treatment.</p> |

| Plan and requested actions | |
|--|--|
| Subheading | Clinical description |
| Actions | <p>Including planned investigations, procedures and treatment for a patient's identified conditions and priorities:</p> <ul style="list-style-type: none"> a) person responsible – name and designation/department/hospital/patient/etc responsible for carrying out the proposed action, and where action should take place b) action – requested, planned or completed c) When action requested for – requested date, time, or period – as relevant d) suggested strategies – suggested strategies for potential problems, eg, telephone contact for advice. |
| Agreed with patient or legitimate patient representative | Indicates whether the patient or legitimate representative has agreed the entire plan or individual aspects of treatment, expected outcomes, risks and alternative treatments if any (yes/no). |
| Person completing record | |
| Subheading | |
| Name | |
| Designation or role | |
| Grade | |
| Specialty | |
| Date completed | |
| Distribution list | |
| Subheading | Clinical description |
| Distribution list | Other individuals to receive copies of this communication. |

Section 5: Outpatient record headings

Outpatient record standards: standard headings for the clinical information recorded in an outpatient setting, including the initial and follow-up outpatient visits, and included in the outpatient letter to the GP and patient.

Not all headings will need to be used in all care settings or circumstances, and the order in which they appear in EHR applications, communications and letters can be agreed by system providers and end users.

The outpatient standards also include the administrative information that precisely defines the attributes of outpatient and ambulatory care sessions.

| GP practice | |
|------------------------|--|
| Subheading | Clinical description |
| GP name | Where the patient or patient's representative offers the name of a GP as their usual GP. |
| GP practice details | Name, address, email, telephone number, fax of the patient's registered GP practice. |
| GP practice identifier | National code which identifies the practice. |

| Patient demographics | |
|--------------------------|---|
| Subheading | Clinical description |
| Patient name | The full name of the patient. Also patient preferred name: the name by which a patient wishes to be addressed. |
| Date of birth | The date of birth of the patient. |
| Patient sex | Sex at birth. Determines how the individual will be treated clinically. |
| Gender | As the patient wishes to portray themselves. |
| Ethnicity | The ethnicity of a person as specified by the person. |
| NHS number | The unique identifier for a patient within the NHS in England and Wales. |
| Other identifier | Country specific or local identifier, eg, Community Health Index (CHI) in Scotland. Two data items: <ul style="list-style-type: none">• type of identifier• identifier. |
| Patient address | Patient usual place of residence. |
| Patient telephone number | Telephone contact details of the person. To include, eg, mobile, work and home number if available. Two data items: <ul style="list-style-type: none">• type• number. |
| Patient email address | Email address of the patient. |

(continued overleaf)

| Subheading | Clinical description |
|---------------------------|---|
| Communication preferences | Preferred contact method, eg, sign language, letter, phone, etc. Also preferred written communication format, eg, large print, braille. |
| Relevant contacts | Eg next of kin, main informal carer, emergency contact. Including: <ul style="list-style-type: none"> • full name • relationship (eg, next of kin) • role (eg, court appointed deputy) • contact details. |

Special requirements

| Subheading | Clinical description |
|----------------------|--|
| Special requirements | Eg level of language (literacy); preferred language (interpreter required)/ambulance required/ other transport arrangements required/ any other special requirements. Includes: <ul style="list-style-type: none"> • preferred language • interpreter required • advocate required • transport required, etc. |

Participation in research

| Subheading | Clinical description |
|---------------------------|--|
| Participation in research | This is to flag participation in a clinical trial. This may include whether participation in a trial has been offered, refused or accepted, the name of the trial, drug/intervention tested, enrolment date, duration of treatment and follow up, and contact number for adverse events or queries. |

Outpatient details

| Subheading | Clinical description |
|---------------------|---|
| Contact type | First contact, follow-up contact. Also scheduled, unscheduled. This is always a coded response. |
| Consultation method | Face to face, telephone, teleconference, etc. |
| Purpose of contact | Explanatory statement of the purpose of the contact. Eg unscheduled contact because patient concerned, monitoring, screening, diagnosis, assessment, pre-admission assessment, etc. |
| Patient location | This is the physical location of the patient. For inpatient, eg, hospital ward, bed, theatre. For ambulatory care, eg, health centre, clinic, resource centre, patient's home. |
| Appointment time | The time the patient was due to be seen. |

| Subheading | Clinical description |
|-------------------------------------|---|
| Time patient seen | The time the patient was seen. |
| Time consultation finished | To calculate duration of consultation. |
| Specialty | Specialties designated by royal colleges and faculties. Eg orthopaedics, renal medicine, endocrinology, etc. |
| Service | Subspecialties, treatment functions or services. Eg hand surgery, back surgery, hand clinic, TIA clinic, falls clinic, speech and language therapy, dialysis, family therapy, pre-admission assessment clinic, etc. |
| Responsible healthcare professional | The name and designation of the consultant, nurse consultant, midwife, physiotherapist, etc. who has overall responsibility for the patient (may not actually see the patient). |
| Seen by | Doctor, nurse or other healthcare professional who sees the patient. Record the most senior member of staff present (eg, ward round or where there is a junior member of staff being supervised by a more senior staff member). Includes: <ul style="list-style-type: none"> • name • role • telephone number. |
| Care professional(s) present | The name and designation of the additional individuals or team members including consultant(s), nurse consultant(s), physiotherapist(s), surgeon(s), social worker(s), etc. Eg where two or more care professionals are jointly running a session: <ul style="list-style-type: none"> • name • role • ID. |
| Person accompanying patient | Identify others accompanying the patient, eg, relative, friend, informal carer, advocate. If the patient was not present, was an authorised representative present? Includes: <ul style="list-style-type: none"> • name • relationship (spouse, etc) • role (patient advocate, etc). |

Referral details

| Subheading | Clinical description |
|------------------|---|
| Referrer details | Name, designation, organisation and contact details of referrer. If not an individual, this could be, eg, GP surgery, department, specialty, subspecialty, educational institution, mental health etc. Also needs to include self-referral. Includes: <ul style="list-style-type: none"> • name • role • specialty, department or team • organisation • contact details, eg, email, fax, telephone. |

(continued overleaf)

| Subheading | Clinical description |
|---------------------|--|
| Referral method | A method of referral is the form in which a referral is sent and received. This may be a letter, email, transcript of a telephone conversation, Choose and Book, in person (self-referral), unknown etc. |
| Referral to | Name, designation and organisation. If not an individual, this could be a service, eg, GP surgery, department, specialty, subspecialty, educational institution, mental health etc. Includes: <ul style="list-style-type: none">• name• role• specialty, team, department• organisation. |
| Urgency of referral | Referrer's assessment of urgency (eg, urgent/soon/routine). May include reason if other than routine. Eg two data items: <ul style="list-style-type: none">• level of urgency• reason. |

History

| Subheading | Clinical description |
|---|--|
| Reason for referral | A clear statement of the purpose of the person making the referral, eg, diagnosis, treatment, transfer of care due to relocation, investigation, second opinion, management of the patient (eg, palliative care), provide referrer with advice/guidance. This may include referral because of carer's concerns. |
| Patient's reason for referral | Patient stated reason for referral. This may include any discussions that took place, the level of shared decision making involved, information about patient's source of advice. This may be expressed on behalf of the patient, eg, by parent or carer. |
| Presenting complaints or issues | The list and description of the health problems and issues experienced by the patient resulting in their attendance. These may include disease state, medical condition, response and reactions to therapies. Eg blackout, dizziness, chest pain, follow up from admission, falls, a specific procedure, investigation or treatment. |
| History of each presenting complaint or issue | Information directly related to the development and characteristics of each presenting complaint (eg including travel history). Including if the information is given by the patient or their carer. |
| History since last contact | History since last attendance, discharge from hospital, etc. |
| Information brought by patient | Eg Patient Passport, example diary data, pre-completed questionnaire, etc. |
| Relevant past medical, surgical and mental health history | The record of the patient's significant medical, surgical and mental health history. Including relevant previous diagnoses, problems and issues, procedures, investigations, specific anaesthesia issues, etc (will include dental and obstetric history). |

Safety alerts

| Subheading | Clinical description |
|-----------------|--|
| Risks to self | Risks the patient poses to themself, eg, suicide, overdose, self-harm, self-neglect. |
| Risks to others | Risks to care professional or third party. |

Medications and medical devices

| Subheading | Clinical description |
|-------------------------------|--|
| Medication name | May be generic name or brand name (as appropriate). |
| Medication form | Eg capsule, drops, tablet, lotion etc. |
| Route | Medication administration description (oral, IM, IV, etc): may include method of administration (eg, by infusion, via nebuliser, via NG tube) and/or site of use (eg, 'to wound', 'to left eye', etc). |
| Dose | <p>This is a record of the total amount of the active ingredient(s) to be given at each administration.</p> <p>It should include, eg, units of measurement, number of tablets, volume/concentration of liquid, number of drops, etc.</p> |
| Medication frequency | Frequency of taking or administration of the therapeutic agent or medication. |
| Additional instructions | <p>Allows for:</p> <ul style="list-style-type: none"> • requirements for adherence support, eg, compliance aids, prompts and packaging requirements • additional information about specific medicines, eg, where specific brand required • patient requirements, eg, unable to swallow tablets. |
| Do not discontinue warning | To be used on a case-by-case basis if it is vital not to discontinue a medicine in a specific patient scenario. |
| Reason for medication | Reason for medication being prescribed, where known. |
| Medication recommendations | Suggestions about duration and/or review, ongoing monitoring requirements, advice on starting, discontinuing or changing medication. |
| Medication change | Where a change is made to the medication ie one drug stopped and another started or, eg, dose, frequency or route is changed. |
| Reason for medication change | Reason for change in medication, eg, sub-therapeutic dose, patient intolerant. |
| Medicine administered | Record of administration to the patient, including self-administration. |
| Reason for non-administration | Reason why drug not administered (eg, patient refused, patient unavailable, drug not available). |
| Relevant previous medications | Record of relevant previous medications. |
| Medical devices | The record of dietary supplements, dressings and equipment that the patient is currently taking or using. |

| Allergies and adverse reaction | |
|---------------------------------------|--|
| Subheading | Clinical description |
| Causative agent | The agent such as food, drug or substances that has caused or may cause an allergy, intolerance or adverse reaction in this patient. |
| Description of the reaction | A description of the manifestation of the allergic or adverse reaction experienced by the patient. This may include: <ul style="list-style-type: none"> • manifestation, eg, skin rash • type of reaction (allergic, adverse, intolerance) • severity of the reaction • certainty • evidence (eg, results of investigations). |
| Probability of recurrence | Probability of the reaction (allergic, adverse, intolerant) occurring. |
| Date first experienced | When the reaction was first experienced. May be a date or partial date (eg, year) or text (eg, during childhood). |

| Legal information | |
|--|--|
| Subheading | Clinical description |
| Consent for treatment record | Whether consent has been obtained for the treatment. May include where record of consent is located or record of consent. |
| Mental capacity assessment | Whether an assessment of the mental capacity of the (adult) patient has been undertaken, if so who carried it out, when and the outcome of the assessment. Also record best interests decision if patient lacks capacity. |
| Advance decisions about treatment | Three items: <ul style="list-style-type: none"> • whether there are written documents, completed and signed when a person is legally competent, that explain a person's medical wishes in advance, allowing someone else to make treatment decisions on his or her behalf late in the disease process • location of these documents • may be copy of the document itself. |
| Lasting or enduring power of attorney or similar | Record of individual involved in healthcare decision on behalf of the patient if the patient lacks capacity. This includes: <ul style="list-style-type: none"> • whether there is a person with lasting or enduring power of attorney, independent mental capacity advocate (IMCA), court appointed deputy • name and contact details for person. |
| Organ and tissue donation | Two data items: <ul style="list-style-type: none"> – Has the person given consent for organ and/or tissue donation (yes/no)? – The location of the relevant information/documents. |
| Consent relating to child | Consideration of age and competency, including Gillick competency. Record of person with parental responsibility or appointed guardian where child lacks competency. |

| Subheading | Clinical description |
|--------------------------------|--|
| Consent to information sharing | Record of consent to information sharing, including any restrictions on sharing information with others, eg, family members, other healthcare professionals. Also use of identifiable information for research purposes. |
| Safeguarding issues | Any legal matters relating to safeguarding of a vulnerable child or adult, eg, child protection plan, child in need, protection of vulnerable adult. |

Social context

| Subheading | Clinical description |
|-----------------------|---|
| Household composition | Eg: lives alone, lives with family, lives with partner, etc. This may be plain text. |
| Lives alone | Yes/no/don't know (Y/N/DK). |
| Lifestyle | The record of lifestyle choices made by the patient which are pertinent to his or her health and well-being, eg, the record of the patient's physical activity level, pets, hobbies, sexual habits and the current and previous use of recreational drugs. |
| Smoking | Latest or current smoking observation. |
| Alcohol intake | Latest or current alcohol consumption observation. |
| Occupational history | The current and/or previous relevant occupation(s) of the patient/individual. This may include educational history. |
| Social circumstances | The record of a patient's social background, network and personal circumstances, eg, housing, religious, ethnic and spiritual needs, social concerns and whether the patient has dependants or is a carer. May include reference to safeguarding issues that are recorded elsewhere in the record. |
| Services and care | The description of services and care providing support for patient's health and social well-being. |

Family history

| Subheading | Clinical description |
|----------------|--|
| Family history | The record of relevant illness in family relations deemed to be significant to the care or health of the patient, including mental illness and suicide, genetic information etc. |

Review of systems

| Subheading | Clinical description |
|-------------------|--|
| Review of systems | The clinical review of systems. The record of clinical information gathered in responses to questions to the patient about general symptoms from various physiological systems, including food intake (increasing/decreasing), weight change, swallowing difficulties, mood/anxiety, etc. |

| Patient and carer concerns | |
|---|---|
| Subheading | Clinical description |
| Patient's and carer's concerns, expectations and wishes | Description of the concerns, wishes or goals of the patient, patient representative or carer. This could be the carer giving information if the patient is not competent, or the parent of a young child. |
| Examination findings | |
| Subheading | Clinical description |
| General appearance | The record of a clinician's 'first impression' assessment including general clinical examination finding, eg, clubbing, anaemia, jaundice, obese/malnourished/cachectic, height, weight, etc. |
| Vital signs | The record of essential physiological measurements, eg, heart rate, blood pressure, temperature, pulse, respiratory rate, level of consciousness. Use of National Early Warning Score (NEWS) chart where appropriate. |
| Mental state | Formal mental state examination or general description, eg, depression, anxiety, confusion, delirium. |
| Head and neck examination | The record of findings from the head and neck examination. |
| Oral examination | The record of findings from the oral examination. |
| Cardiovascular system | The record of findings from the cardiovascular system examination. |
| Respiratory system | The record of findings from the respiratory system examination. |
| Abdomen | The record of findings from the abdominal examination. |
| Genitourinary | The record of findings from the genitourinary examination. |
| Nervous system | The record of findings from the nervous system examination. |
| Musculoskeletal system | The record of findings from the musculoskeletal system examination. |
| Skin | The record of findings from examination of the skin. |
| Examination procedure | A procedure completed as part of the examination of the patient. Eg sigmoidoscopy, lumbar puncture, pleural tap, etc. |
| Assessment scales | |
| Subheading | Clinical description |
| Assessment scales | Assessment scales used, eg, New York Heart Failure scale, Activities of Daily Living (ADL), cognitive function, mood assessment scales, developmental scales, MUST (nutrition), BPI (pain), etc. |

| Problems and issues | |
|---------------------------------------|---|
| Subheading | Clinical description |
| Problems and issues | Summary of problems that require investigation or treatment. This would include significant examination findings which are likely to have relevance and yet are not a diagnosis. In mental health and psychiatry, this may be the place for formulation. |
| Diagnoses | |
| Subheading | Clinical description |
| Diagnosis | Confirmed diagnosis; active diagnosis being treated. Include the stage of the disease where relevant. |
| Differential diagnosis | The determination of which one of several diseases may be producing the symptoms. |
| Relevant clinical risk factors | |
| Subheading | Clinical description |
| Relevant clinical risk factors | Factors that have been shown to be associated with the development of a medical condition being considered as a diagnosis/differential diagnosis. Eg being overweight, smoker, no use of sun screen, enzyme deficiency, poor sight (can impact on falls), etc. |
| Clinical risk assessment | Specific risk assessments required/undertaken, including thromboembolic risk assessment, etc. |
| Risk mitigation | Action taken to reduce the clinical risk, including thromboembolic preventative action and date actioned. |
| Clinical summary | |
| Subheading | Clinical description |
| Clinical summary | Narrative summary of the episode. Where possible, very brief. This may include interpretation of findings and results; differential diagnoses, opinion and specific action(s). Planned actions will be recorded under 'plan'. |

| Investigations and results | |
|-----------------------------------|---|
| Subheading | Clinical description |
| Investigations requested | This includes a name or description of the investigation requested and the date requested. |
| Investigation results | The result of the investigation (this includes the result value, with unit of observation and reference interval where applicable and date), and plans for acting upon investigation results. |
| Procedures requested | These are the diagnostic procedures that have actually been requested (and the date requested). |

| Procedures | |
|------------------------------------|--|
| Subheading | Clinical description |
| Procedure | The therapeutic procedure performed. This could include site and must include laterality where applicable. |
| Complications related to procedure | Details of any intra-operative complications encountered during the procedure, arising during the patient's stay in the recovery unit or directly attributable to the procedure. The intent is to be plain text and or images but use codes wherever possible. |
| Specific anaesthesia issues | Details of any adverse reaction to any anaesthetic agents including local anaesthesia. Problematic intubation, transfusion reaction, etc. |

| Plan and requested actions | |
|--|--|
| Subheading | Clinical description |
| Actions | Including planned investigations, procedures and treatment for a patient's identified conditions and priorities: a) person responsible – name and designation/department/hospital/patient/etc responsible for carrying out the proposed action, and where action should take place b) action – requested, planned or completed c) when action requested for – requested date, time, or period – as relevant d) suggested strategies – suggested strategies for potential problems, eg, telephone contact for advice. |
| Agreed with patient or legitimate patient representative | Indicates whether the patient or legitimate representative has agreed the entire plan or individual aspects of treatment, expected outcomes, risks and alternative treatments if any (yes/no). |
| Next appointment details | Eg booking follow-up appointment, etc. |

Information given

| Subheading | Clinical description |
|------------------------------|---|
| Information and advice given | <p>This includes:</p> <ul style="list-style-type: none"> – what information – to whom it was given. <p>The oral or written information or advice given to the patient, carer, other authorised representative, care professional or other third party. May include advice about actions related to medicines or other ongoing care activities on an 'information prescription'.</p> <p>State here if there are concerns about the extent to which the patient and/or carer understands the information provided about diagnosis, prognosis and treatment.</p> |

Person completing record

| Subheading |
|---------------------|
| Name |
| Designation or role |
| Grade |
| Specialty |
| Date completed |

Distribution list

| Subheading | Clinical description |
|-------------------|--|
| Distribution list | Other individuals to receive copies of this communication. |

Section 6: Referral record headings

Referral record standards: the referral headings are primarily intended for recording the clinical information in referral communication between general practitioners (GP) and hospital doctors, copied to the patient. However, they may be used for other types of referral.

Not all headings will need to be used in all care settings or circumstances, and the order in which they appear in EHR applications, communications and letters can be agreed by system providers and end users.

| Patient demographics | |
|---------------------------|--|
| Subheading | Clinical description |
| Patient name | The full name of the patient. Also patient preferred name: the name by which a patient wishes to be addressed. |
| Date of birth | The date of birth of the patient. |
| Patient sex | Sex at birth. Determines how the individual will be treated clinically. |
| Gender | As the patient wishes to portray themselves. |
| Ethnicity | The ethnicity of a person as specified by the person. |
| NHS number | The unique identifier for a patient within the NHS in England and Wales. |
| Other identifier | Country specific or local identifier, eg, Community Health Index (CHI) in Scotland. Two data items: <ul style="list-style-type: none">• type of identifier• identifier. |
| Patient address | Patient usual place of residence. |
| Patient telephone number | Telephone contact details of the person. To include, eg, mobile, work and home number if available. Two data items: <ul style="list-style-type: none">• type• number. |
| Patient email address | Email address of the patient. |
| Communication preferences | Preferred contact method, eg, sign language, letter, phone, etc. Also preferred written communication format, eg, large print, braille. |
| Relevant contacts | Eg next of kin, main informal carer, emergency contact. Including: <ul style="list-style-type: none">• full name• relationship (eg, next of kin)• role (eg, court appointed deputy)• contact details. |

GP practice

| Subheading | Clinical description |
|------------------------|--|
| GP name | Where the patient or patient's representative offers the name of a GP as their usual GP. |
| GP practice details | Name, address, email, telephone number, fax of the patient's registered GP practice. |
| GP practice identifier | National code which identifies the practice. |

Referral details

| Subheading | Clinical description |
|-------------------------------|---|
| Referral to | Name, designation and organisation. If not an individual, this could be a service, eg, GP surgery, department, specialty, subspecialty, educational institution, mental health etc. Includes: <ul style="list-style-type: none">• name• role• specialty, team, department• organisation. |
| Referrer details | Name, designation, organisation and contact details of referrer. If not an individual, this could be, eg, GP surgery, department, specialty, subspecialty, educational institution, mental health etc. Also needs to include self-referral. Includes: <ul style="list-style-type: none">• name• role• specialty, department or team• organisation• contact details, eg, email, fax, telephone. |
| Referral method | A method of referral is the form in which a referral is sent and received. This may be a letter, email, transcript of a telephone conversation, Choose and Book, in person (self-referral), unknown etc. |
| Person to attend with patient | Identify others who will/may accompany the patient, eg, relative, carer, chaperone. Includes: <ul style="list-style-type: none">• name• relationship (friend, relative, etc)• role (patient advocate, chaperone etc)• attendee's special requirements. |
| Attachments | Documents included as attachments which accompany the communication Data items: <ul style="list-style-type: none">• number of attachments• type of attachments• attached documents. |
| Referral criteria | Records whether specific criteria required for referral, to a particular service, have been met (may be nationally or locally determined). |
| Details of other referrals | Other referrals related to this or associated conditions. |

Special requirements

| Subheading | Clinical description |
|----------------------|---|
| Special requirements | Eg level of language (literacy); preferred language (interpreter required)/ambulance required/other transport arrangements required/any other special requirements. Includes: <ul style="list-style-type: none">• preferred language• interpreter required• advocate required• transport required, etc. |

Participation in research

| Subheading | Clinical description |
|---------------------------|--|
| Participation in research | This is to flag participation in a clinical trial. This may include whether participation in a trial has been offered, refused or accepted, the name of the trial, drug/intervention tested, enrolment date, duration of treatment and follow up, and contact number for adverse events or queries. |

History

| Subheading | Clinical description |
|---|--|
| Reason for referral | A clear statement of the purpose of the person making the referral, eg, diagnosis, treatment, transfer of care due to relocation, investigation, second opinion, management of the patient (eg, palliative care), provide referrer with advice/guidance. This may include referral because of carer's concerns. |
| Expectation of referral | A clear statement of the expectations of the person making the referral as to the management of the patient, eg, advice only, diagnosis, treatment, etc. |
| Patient's reason for referral | Patient stated reason for referral. This may include any discussions that took place, the level of shared decision making involved, information about patient's source of advice. This may be expressed on behalf of the patient, eg, by parent or carer. |
| Patient's expectation of referral | Patient's expectations of the referral including preferences. This may include any discussions that took place, the level of shared decision making involved, information about patient's source of advice. |
| Presenting complaints or issues | The list and description of the health problems and issues experienced by the patient resulting in their attendance. These may include disease state, medical condition, response and reactions to therapies. Eg blackout, dizziness, chest pain, follow up from admission, falls, a specific procedure, investigation or treatment. |
| History of each presenting complaint or issue | Information directly related to the development and characteristics of each presenting complaint (eg, including travel history). Including if the information is given by the patient or their carer. |

| Subheading | Clinical description |
|---|--|
| Relevant past medical, surgical and mental health history | The record of the patient's significant medical, surgical and mental health history. Including relevant previous diagnoses, problems and issues, procedures, investigations, specific anaesthesia issues, etc (will include dental and obstetric history). |
| Management to date | Referrals, management, investigations and treatment that have already been undertaken, including patient managing their symptoms. Including: <ul style="list-style-type: none">• procedures conducted – procedures carried out (and the date) and procedure report. |
| Urgency of referral | Referrer's assessment of urgency (eg, urgent/soon/routine). May include reason if other than routine. Eg two data items: <ul style="list-style-type: none">• level of urgency• reason. |

Examination findings

| Subheading | Clinical description |
|----------------------|---|
| Examination findings | The record of findings from clinical examination. |
| Vital signs | The record of essential physiological measurements, eg, heart rate, blood pressure, temperature, pulse, respiratory rate, level of consciousness. Use of National Early Warning Score (NEWS) chart where appropriate. |

Assessment scales

| Subheading | Clinical description |
|-------------------|--|
| Assessment scales | Assessment scales used, eg, New York Heart Failure scale, Activities of Daily Living (ADL), cognitive function, mood assessment scales, developmental scales, MUST (nutrition), BPI (pain), etc. |

Relevant clinical risk factors

| Subheading | Clinical description |
|--------------------------------|---|
| Relevant clinical risk factors | Factors that have been shown to be associated with the development of a medical condition being considered as a diagnosis/differential diagnosis. Eg being overweight, smoker, no use of sun screen, enzyme deficiency, poor sight (can impact on falls), etc. |
| Clinical risk assessment | Specific risk assessments required/undertaken, including thromboembolic risk assessment, etc. |
| Risk mitigation | Action taken to reduce the clinical risk, including thromboembolic preventative action and date actioned. |

| Investigations and results | |
|-----------------------------------|---|
| Subheading | Clinical description |
| Investigations requested | This includes a name or description of the investigation requested and the date requested. |
| Investigation results | The result of the investigation (this includes the result value, with unit of observation and reference interval where applicable and date), and plans for acting upon investigation results. |
| Procedures requested | These are the diagnostic procedures that have actually been requested (and the date requested). |

| Family history | |
|-----------------------|--|
| Subheading | Clinical description |
| Family history | The record of relevant illness in family relations deemed to be significant to the care or health of the patient, including mental illness and suicide, genetic information etc. |

| Social context | |
|-----------------------|---|
| Subheading | Clinical description |
| Household composition | Eg: lives alone, lives with family, lives with partner, etc. This may be plain text. |
| Lives alone | Yes/no/don't know (Y/N/DK). |
| Lifestyle | The record of lifestyle choices made by the patient which are pertinent to his or her health and well-being, eg, the record of the patient's physical activity level, pets, hobbies, sexual habits and the current and previous use of recreational drugs. |
| Smoking | Latest or current smoking observation. |
| Alcohol intake | Latest or current alcohol consumption observation. |
| Occupational history | The current and/or previous relevant occupation(s) of the patient/individual. This may include educational history. |
| Social circumstances | The record of a patient's social background, network and personal circumstances, eg, housing, religious, ethnic and spiritual needs, social concerns and whether the patient has dependants or is a carer. May include reference to safeguarding issues that are recorded elsewhere in the record. |
| Services and care | The description of services and care providing support for patient's health and social well-being. |

| Patient and carer concerns | |
|---|---|
| Subheading | Clinical description |
| Patient's and carer's concerns, expectations and wishes | Description of the concerns, wishes or goals of the patient, patient representative or carer. This could be the carer giving information if the patient is not competent, or the parent of a young child. |
| Medications and medical devices | |
| Subheading | Clinical description |
| Medication name | May be generic name or brand name (as appropriate). |
| Medication form | Eg capsule, drops, tablet, lotion etc. |
| Route | Medication administration description (oral, IM, IV, etc): may include method of administration (eg, by infusion, via nebuliser, via NG tube) and/or site of use (eg, 'to wound', 'to left eye', etc). |
| Dose | This is a record of the total amount of the active ingredient(s) to be given at each administration. It should include, eg, units of measurement, number of tablets, volume/concentration of liquid, number of drops, etc. |
| Medication frequency | Frequency of taking or administration of the therapeutic agent or medication. |
| Additional instructions | Allows for: <ul style="list-style-type: none"> • requirements for adherence support, eg, compliance aids, prompts and packaging requirements • additional information about specific medicines, eg, where specific brand required • patient requirements, eg, unable to swallow tablets. |
| Do not discontinue warning | To be used on a case-by-case basis if it is vital not to discontinue a medicine in a specific patient scenario. |
| Reason for medication | Reason for medication being prescribed, where known. |
| Medication recommendations | Suggestions about duration and/or review, ongoing monitoring requirements, advice on starting, discontinuing or changing medication. |
| Medication status | Whether or not a medication is being administered, eg, started, stopped, suspended, reinstated. Record date for each change in status. |
| Medication change | Where a change is made to the medication ie one drug stopped and another started or, eg, dose, frequency or route is changed. |
| Reason for medication change | Reason for change in medication, eg, sub-therapeutic dose, patient intolerant. |
| Relevant previous medications | Record of relevant previous medications. |
| Medical devices | The record of dietary supplements, dressings and equipment that the patient is currently taking or using. |

Allergies and adverse reaction

| Subheading | Clinical description |
|-----------------------------|--|
| Causative agent | The agent such as food, drug or substances that has caused or may cause an allergy, intolerance or adverse reaction in this patient. |
| Description of the reaction | A description of the manifestation of the allergic or adverse reaction experienced by the patient. This may include: <ul style="list-style-type: none"> • manifestation, eg, skin rash • type of reaction (allergic, adverse, intolerance) • severity of the reaction • certainty • evidence (eg, results of investigations). |
| Probability of recurrence | Probability of the reaction (allergic, adverse, intolerant) occurring. |
| Date first experienced | When the reaction was first experienced. May be a date or partial date (eg, year) or text (eg, during childhood). |

Safety alerts

| Subheading | Clinical description |
|-----------------|--|
| Risks to self | Risks the patient poses to themselves, eg, suicide, overdose, self-harm, self-neglect. |
| Risks to others | Risks to care professional or third party. |

Legal information

| Subheading | Clinical description |
|--|--|
| Consent for treatment record | Whether consent has been obtained for the treatment. May include where record of consent is located or record of consent. |
| Mental capacity assessment | Whether an assessment of the mental capacity of the (adult) patient has been undertaken, if so who carried it out, when and the outcome of the assessment. Also record best interests decision if patient lacks capacity. |
| Advance decisions about treatment | Three items: <ul style="list-style-type: none"> • whether there are written documents, completed and signed when a person is legally competent, that explain a person's medical wishes in advance, allowing someone else to make treatment decisions on his or her behalf late in the disease process • location of these documents • may be copy of the document itself. |
| Lasting or enduring power of attorney or similar | Record of individual involved in healthcare decision on behalf of the patient if the patient lacks capacity. This includes: <ul style="list-style-type: none"> • whether there is a person with lasting or enduring power of attorney, independent mental capacity advocate (IMCA), court appointed deputy • name and contact details for person. |

| Subheading | Clinical description |
|--------------------------------|--|
| Organ and tissue donation | <p>Two data items:</p> <ul style="list-style-type: none"> – has the person given consent for organ and/or tissue donation (yes/no) – the location of the relevant information/documents. |
| Consent relating to child | <p>Consideration of age and competency, including Gillick competency.</p> <p>Record of person with parental responsibility or appointed guardian where child lacks competency.</p> |
| Consent to information sharing | Record of consent to information sharing, including any restrictions on sharing information with others, eg, family members, other healthcare professionals. Also use of identifiable information for research purposes. |
| Safeguarding issues | Any legal matters relating to safeguarding of a vulnerable child or adult, eg, child protection plan, child in need, protection of vulnerable adult. |

| Information given | |
|------------------------------|---|
| Subheading | Clinical description |
| Information and advice given | <p>This includes:</p> <ul style="list-style-type: none"> – what information – to whom it was given. <p>The oral or written information or advice given to the patient, carer, other authorised representative, care professional or other third party. May include advice about actions related to medicines or other ongoing care activities on an 'information prescription'.</p> <p>State here if there are concerns about the extent to which the patient and/or carer understands the information provided about diagnosis, prognosis and treatment.</p> |

| Person completing record | |
|--------------------------|--|
| Subheading | |
| Name | |
| Designation or role | |
| Date completed | |

| Distribution list | |
|-------------------|--|
| Subheading | Clinical description |
| Distribution list | Other individuals to receive copies of this referral letter. |

Section 7: Core clinical headings

Core clinical heading standards: the core clinical headings are those that are the priority for inclusion in EHRs, as they are generally items that are the priority for coding using SNOMED CT.

| GP practice | |
|---------------------------|--|
| Subheading | Clinical description |
| GP name | Where the patient or patient's representative offers the name of a GP as their usual GP. |
| GP practice details | Name, address, email, telephone number, fax of the patient's registered GP practice. |
| GP practice identifier | National code which identifies the practice. |
| Patient demographics | |
| Subheading | Clinical description |
| Patient name | The full name of the patient. Also patient preferred name: the name by which a patient wishes to be addressed. |
| Date of birth | The date of birth of the patient |
| Patient sex | Sex at birth. Determines how the individual will be treated clinically. |
| Gender | As the patient wishes to portray themselves. |
| Ethnicity | The ethnicity of a person as specified by the person. |
| NHS number | The unique identifier for a patient within the NHS in England and Wales. |
| Other identifier | Country specific or local identifier, eg, Community Health Index (CHI) in Scotland. Two data items: <ul style="list-style-type: none">• type of identifier• identifier. |
| Patient address | Patient usual place of residence. |
| Patient telephone number | Telephone contact details of the person. To include, eg, mobile, work and home number if available. Two data items: <ul style="list-style-type: none">• type• number. |
| Patient email address | Email address of the patient. |
| Communication preferences | Preferred contact method, eg, sign language, letter, phone, etc. Also preferred written communication format, eg, large print, braille. |
| Relevant contacts | Eg next of kin, main informal carer, emergency contact. Including: <ul style="list-style-type: none">• full name• relationship (eg, next of kin)• role (eg, court appointed deputy)• contact details. |

Participation in research

| Subheading | Clinical description |
|---------------------------|---|
| Participation in research | <p>This is to flag participation in a clinical trial.</p> <p>This may include whether participation in a trial has been offered, refused or accepted, the name of the trial, drug/intervention tested, enrolment date, duration of treatment and follow up, and contact number for adverse events or queries.</p> |

Reasons for contact

| Subheading | Clinical description |
|-------------------------------|---|
| Reason for admission | The health problems and issues experienced by the patient resulting in their referral by a healthcare professional for hospital admission, eg, chest pain, blackout, fall, a specific procedure, investigation or treatment. |
| Reason for handover | A clear statement of the reason for the temporary or permanent handover of care, eg, low potassium, immediately post-op, unstable medical condition. |
| Reason for referral | <p>A clear statement of the purpose of the person making the referral, eg, diagnosis, treatment, transfer of care due to relocation, investigation, second opinion, management of the patient (eg, palliative care), provide referrer with advice/guidance.</p> <p>This may include referral because of carer's concerns.</p> |
| Patient's reason for referral | <p>Patient stated reason for referral. This may include any discussions that took place, the level of shared decision making involved, information about patient's source of advice.</p> <p>This may be expressed on behalf of the patient, eg, by parent or carer.</p> |

Presenting complaints or issues

| Subheading | Clinical description |
|---------------------------------|--|
| Presenting complaints or issues | The list and description of the health problems and issues experienced by the patient resulting in their attendance. These may include disease state, medical condition, response and reactions to therapies. Eg blackout, dizziness, chest pain, follow up from admission, falls, a specific procedure, investigation or treatment. |

Family history

| Subheading | Clinical description |
|----------------|--|
| Family history | The record of relevant illness in family relations deemed to be significant to the care or health of the patient, including mental illness and suicide, genetic information etc. |

Diagnoses

| Subheading | Clinical description |
|--------------------------------------|---|
| Diagnosis | Confirmed diagnosis; active diagnosis being treated. Include the stage of the disease where relevant. |
| Differential diagnosis | The determination of which one of several diseases may be producing the symptoms. |
| Episode (first, new, other, ongoing) | <ul style="list-style-type: none"> • First episode • New episode • Other, past or ongoing episode. |
| Date diagnosis made | The date when the diagnosis was made. |
| Date of first presentation | The date the diagnosis condition first presented. |

Procedures

| Subheading | Clinical description |
|------------------------------------|--|
| Procedure | The therapeutic procedure performed. This could include site and must include laterality where applicable. |
| Complications related to procedure | Details of any intra-operative complications encountered during the procedure, arising during the patient's stay in the recovery unit or directly attributable to the procedure. The intent is to be plain text and/or images but use codes wherever possible. |
| Specific anaesthesia issues | Details of any adverse reaction to any anaesthetic agents including local anaesthesia. Problematic intubation, transfusion reaction, etc. |

Assessment scales

| Subheading | Clinical description |
|-------------------|--|
| Assessment scales | Assessment scales used, eg, New York Heart Failure scale, Activities of Daily Living (ADL), cognitive function, mood assessment scales, developmental scales, MUST (nutrition), BPI (pain), etc. |

Investigations and results

| Subheading | Clinical description |
|--------------------------|---|
| Investigations requested | This includes a name or description of the investigation requested and the date requested. |
| Investigations results | The result of the investigation (this includes the result value, with unit of observation and reference interval where applicable and date), and plans for acting upon investigation results. |

| Subheading | Clinical description |
|---|---|
| Procedures requested | These are the diagnostic procedures that have actually been requested (and the date requested). |
| Problems and issues | |
| Subheading | Clinical description |
| Problems and issues | Summary of problems that require investigation or treatment. This would include significant examination findings which are likely to have relevance and yet are not a diagnosis. In mental health and psychiatry, this may be the place for formulation. |
| Patient and carer concerns | |
| Subheading | Clinical description |
| Patient's and carer's concerns, expectations and wishes | Description of the concerns, wishes or goals of the patient, patient representative or carer. This could be the carer giving information if the patient is not competent, or the parent of a young child. |
| Medications and medical devices | |
| Subheading | Clinical description |
| Medication name | May be generic name or brand name (as appropriate). |
| Medication form | Eg capsule, drops, tablet, lotion etc. |
| Route | Medication administration description (oral, IM, IV, etc): may include method of administration (eg, by infusion, via nebuliser, via NG tube) and/or site of use (eg, 'to wound', 'to left eye', etc). |
| Dose | This is a record of the total amount of the active ingredient(s) to be given at each administration. It should include, eg, units of measurement, number of tablets, volume/concentration of liquid, number of drops, etc. |
| Medication frequency | Frequency of taking or administration of the therapeutic agent or medication. |
| Additional instructions | Allows for: <ul style="list-style-type: none"> • requirements for adherence support, eg, compliance aids, prompts and packaging requirements • additional information about specific medicines, eg, where specific brand required • patient requirements, eg, unable to swallow tablets. |
| Do not discontinue warning | To be used on a case-by-case basis if it is vital not to discontinue a medicine in a specific patient scenario. |
| Reason for medication | Reason for medication being prescribed, where known. |

(continued overleaf)

| Subheading | Clinical description |
|-------------------------------|---|
| Medication recommendations | Suggestions about duration and/or review, ongoing monitoring requirements, advice on starting, discontinuing or changing medication. |
| Medication status | Whether or not a medication is being administered, eg, started, stopped, suspended, reinstated. Record date for each change in status. |
| Medication change | Where a change is made to the medication, ie one drug stopped and another started, or eg, dose, frequency or route is changed. |
| Reason for medication change | Reason for change in medication, eg, sub-therapeutic dose, patient intolerant. |
| Medicine administered | Record of administration to the patient, including self-administration. |
| Reason for non-administration | Reason why drug not administered (eg, patient refused, patient unavailable, drug not available). |
| Relevant previous medications | Record of relevant previous medications. |
| Medical devices | The record of dietary supplements, dressings and equipment that the patient is currently taking or using. |

Allergies and adverse reaction

| Subheading | Clinical description |
|-----------------------------|--|
| Causative agent | The agent such as food, drug or substances that has caused or may cause an allergy, intolerance or adverse reaction in this patient. |
| Description of the reaction | A description of the manifestation of the allergic or adverse reaction experienced by the patient. This may include: <ul style="list-style-type: none"> • manifestation, eg, skin rash • type of reaction (allergic, adverse, intolerance) • severity of the reaction • certainty • evidence (eg, results of investigations). |
| Probability of recurrence | Probability of the reaction (allergic, adverse, intolerant) occurring. |
| Date first experienced | When the reaction was first experienced. May be a date or partial date (eg, year) or text (eg, during childhood). |

Safety alerts

| Subheading | Clinical description |
|-------------------|--|
| Risks to self | Risks the patient poses to themselves, eg, suicide, overdose, self-harm, self-neglect. |
| Risks to others | Risks to care professional or third party. |

Plan and requested actions

| Subheading | Clinical description |
|--|--|
| Actions | <p>Including planned investigations, procedures and treatment for a patient's identified conditions and priorities:</p> <ul style="list-style-type: none"> a) person responsible – name and designation/department/hospital/patient/etc responsible for carrying out the proposed action, and where action should take place b) action – requested, planned or completed c) when action requested for – requested date, time, or period – as relevant d) suggested strategies – suggested strategies for potential problems, eg, telephone contact for advice. |
| Agreed with patient or legitimate patient representative | Indicates whether the patient or legitimate representative has agreed the entire plan or individual aspects of treatment, expected outcomes, risks and alternative treatments if any (yes/no). |

Information given

| Subheading | Clinical description |
|------------------------------|---|
| Information and advice given | <p>This includes:</p> <ul style="list-style-type: none"> – what information – to whom it was given. <p>The oral or written information or advice given to the patient, carer, other authorised representative, care professional or other third party. May include advice about actions related to medicines or other ongoing care activities on an 'information prescription'.</p> <p>State here if there are concerns about the extent to which the patient and/or carer understands the information provided about diagnosis, prognosis and treatment.</p> |

Legal information

| Subheading | Clinical description |
|-----------------------------------|---|
| Consent for treatment record | Whether consent has been obtained for the treatment. May include where record of consent is located or record of consent. |
| Mental capacity assessment | Whether an assessment of the mental capacity of the (adult) patient has been undertaken, if so who carried it out, when and the outcome of the assessment. Also record best interests decision if patient lacks capacity. |
| Advance decisions about treatment | <p>Three items:</p> <ul style="list-style-type: none"> • whether there are written documents, completed and signed when a person is legally competent, that explain a person's medical wishes in advance, allowing someone else to make treatment decisions on his or her behalf late in the disease process • location of these documents • may be copy of the document itself. |

(continued overleaf)

| Subheading | Clinical description |
|--|---|
| Lasting or enduring power of attorney or similar | Record of individual involved in healthcare decision on behalf of the patient if the patient lacks capacity. This includes: <ul style="list-style-type: none"> • whether there is a person with lasting or enduring power of attorney, independent mental capacity advocate (IMCA), court appointed deputy • name and contact details for person. |
| Organ and tissue donation | Two data items: <ul style="list-style-type: none"> – has the person given consent for organ and/or tissue donation (yes/no) – the location of the relevant information/documents. |
| Consent relating to child | Consideration of age and competency, including Gillick competency. Record of person with parental responsibility or appointed guardian where child lacks competency. |
| Consent to information sharing | Record of consent to information sharing, including any restrictions on sharing information with others, eg, family members, other healthcare professionals. Also use of identifiable information for research purposes. |
| Safeguarding issues | Any legal matters relating to safeguarding of a vulnerable child or adult, eg, child protection plan, child in need, protection of vulnerable adult. |

Organisations contributing to the review of all record standards headings

| | |
|---|--|
| Acute and mental health trust medical directors | Clinical Genetics Society |
| Association for Clinical Biochemistry | College of Emergency Medicine |
| Association for Palliative Medicine of Great Britain and Ireland | College of Occupational Therapists |
| Association of British Clinical Diabetologists | Department of Health Informatics Directorate – Patients and Public Clinical Division |
| Association of Cancer Physicians | EMIS |
| Association of Directors of Adult Social Services | Faculty of Occupational Medicine |
| Association of Surgeons of Great Britain and Ireland | Faculty of Pharmaceutical Medicine |
| British Association for Parenteral and Enteral Nutrition | Faculty of Sport and Exercise Medicine |
| British Association for Sexual Health and HIV | Health and Care Professions Council |
| British Association of Audiovestibular Physicians | In Practice Systems |
| British Association of Dermatologists | Intensive Care Society |
| British Association of Oral and Maxillofacial Surgeons | Local Medical Committee Chairs |
| British Association of Otorhinolaryngology | National Voices |
| British Association of Paediatric Surgeons | NHS London |
| British Association of Plastic, Reconstructive and Aesthetic Surgeons | Nursing and Midwifery Council |
| British Association of Stroke Physicians | Nutrition Society |
| British Association of Urological Surgeons | TPP |
| British Cardiovascular Society | Renal Association |
| British Dietetic Association | Royal College of Anaesthetists |
| British Geriatrics Society | Royal College of General Practitioners |
| British Infection Association | Royal College of Midwives |
| British Orthodontic Society | Royal College of Nursing |
| British Orthopaedic Association | Royal College of Obstetricians and Gynaecologists |
| British Pain Society | Royal College of Ophthalmologists |
| British Pharmacological Society | Royal College of Paediatrics and Child Health |
| British Psychological Society | Royal College of Pathologists |
| British Society for Gastroenterology | Royal College of Physicians |
| British Society for Haematology | Royal College of Physicians – Patient and Carer Network |
| British Society for Human Genetics | Royal College of Physicians and Surgeons Glasgow |
| British Society for Immunology | Royal College of Physicians of Edinburgh |
| British Society of Rehabilitation Medicine | Royal College of Psychiatrists |
| British Thoracic Society | Royal College of Radiologists |
| Chartered Society of Physiotherapy | Royal College of Surgeons of Edinburgh |
| Choose and Book clinical leads | Royal Pharmaceutical Society of Great Britain |
| Chronic Pain Policy Coalition | Society of British Neurological Surgeons |
| | UK Terminology Centre |

Organisations which signed off the record standards headings May 2013

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|---|--|
| Association for Clinical Biochemistry | British Thoracic Society |
| Association for Palliative Medicine of Great Britain & Ireland | Chartered Society of Physiotherapy |
| Association of British Clinical Diabetologists | Chronic Pain Policy Coalition (CPPC) |
| Association of Cancer Physicians | Clinical Genetics Society |
| Association of Surgeons of Great Britain and Ireland | College of Emergency Medicine |
| British Association for Parenteral & Enteral Nutrition | College of Occupational Therapists |
| British Association of Audiovestibular Physicians | Faculty of Occupational Medicine |
| British Association of Dermatologists | Faculty of Sport and Exercise Medicine |
| British Association of Otorhinolaryngology (Ears, Nose and Throat) (ENT – UK) | Intensive Care Society |
| British Association of Plastic, Reconstructive and Aesthetic Surgeons | Renal Association |
| British Association of Stroke Physicians | Royal College of Anaesthetists |
| British Association of Urological Surgeons | Royal College of General Practitioners |
| British Cardiovascular Society | Royal College of Midwives |
| British Dietetic Association | Royal College of Nursing |
| British Geriatrics Society | Royal College of Obstetricians and Gynaecologists (RCOG) |
| British Infection Association | Royal College of Ophthalmologists |
| British Orthodontic Society | Royal College of Paediatrics and Child Health |
| British Orthopaedic Association | Royal College of Pathologists |
| British Pain Society | Royal College of Physicians and Surgeons Glasgow |
| British Psychological Society | Royal College of Physicians of Edinburgh |
| British Society for Gastroenterology | Royal College of Psychiatrists |
| British Society for Haematology | Royal College of Radiologists |
| British Society for Genetic Medicine | Royal College of Surgeons of Edinburgh |
| British Society for Immunology | The Royal College of Surgeons of England |
| | Royal Pharmaceutical Society (RPS) |
| | Society of British Neurological Surgeons |



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