HACKETTSTOWN REGIONAL MEDICAL CENTER
JOAN KNECHEL CANCER CENTER
PATIENT ELECTRONIC MEDICAL RECORD

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Cross Referenced: | **Origin: Radiation Oncology**
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SCOPE
All patients receiving radiation therapy in the Radiation Oncology Center

PURPOSE
To provide a an electronic health record as required by the Center for Medicare and Medicaid Services as Meaningful Use compliant.

DEFINITIONS
EMR = Electronic Medical Record

POLICY
The Joan Knechel Cancer Center maintains an electronic medical record for radiation oncology patients that is also assessable to the Medical Records Department. The software utilized must be certified as meaningful use compliant.

PROCEDURE
The EMR allows the direct input of the following information:

1) Scheduling
    a. Treatment
    b. Consultations
    c. Other appointments
    d. Social Worker Distress Assessment and psycho-social assessment
    e. Dosimetry Plans
    f. Physics Reviews
    g. Physician prescription orders

The following information is scanned into the EMR:

1) Patients history and physical dictated by physician into Cerner
2) Physician treatment plans, progress notes and discharge summary
3) Diagnostic Imaging reports
4) Lab / Pathology reports
5) Medical Reports from physicians other than from HRMC

All paper records must be kept in the patient's chart until the patient has had their first follow up visit with the physician within 30 days of discharge from treatment. If the patient does not keep their first follow up visit, upon repeated notifications, the record, after 60 days of treatment discharge may go to the Coordinator for scanning and verification of all paper records in the EMR.

All records scanned must be verified by the Coordinator prior to the shredding of paper documents.