HACKETTSTOWN REGIONAL MEDICAL CENTER
CENTER FOR SLEEP RELATED DISORDERS
POLICY AND PROCEDURES
ORGANIZATION AND MAINTENANCE OF PATIENT CHARTS

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Cross Referenced:	**Origin: Center for Sleep Disorders**
Reviewed Date: 04/12	**Authority: Cardio/Pulmonary Manager**
Revised Date:	**Page: 1 of 1**

PURPOSE: A consistent organization and plan for filing information in patient charts assures that information is readily available and easily found.

POLICY: All sleep patients will have a sleep chart. All charts will be organized in a like manner. Medical information will also be available local Compumedics/NeXus system and Cerner Millenium. Compumedics/Nexus System/Cerner Millenium are in accordance with HIPAA regulations.

PROCEDURE:

The Administrative Assistant and/or Coordinator are primarily responsible for maintaining charts. All sleep-related laboratory procedures and insurance verification are documented in the chart. The tabbed sections are as follows:

Insurance and Correspondence
Technical Notes
PSGs & MSLT
CPAP/BIPAP Titration
Interpretations/ Scoring Report

Each section of the chart contains the following information:

Insurance and Correspondence: **Patient Intake Form Verifying**: Prescription/Prescription Form and referral forms; Patient Consent Form; Patient ID Labels; Sleep Disorders Questionnaire; Compliance Data; Communication Record.

Technical Notes: Sleep Tech Notes; Bedtime/Morning Questionnaire; Epworth Sleepiness Scale; Authorization for Video Recording

PSGs & MSLT: Polysomnographic Summary Report; MSLT Summary Report

CPAP/BIPAP Titration: CPAP/BIPAP Summary Report

Interpretations/Scoring Reports: Raw data reports drafted by score technologist and final dictated reports from interpreting physicians.

- **Communication Record**: is stapled to the inside back cover of patient's chart to track the following dates: Any requests for information from Physician Offices and communication with patient/patient representative**.**
- **Patient intake forms should document**: First contact with the patient, date of referral, appointment date, insurance verification information, date of completion of chart, date correspondence sent to patient.