Organization and Maintenance of Patient Charts

Audience: All personnel in the Sleep Disorder Center.

Purpose: Consistency in filing 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 consistent manner.

Procedure:

- Paper sleep records are maintained by the sleep center personnel in the secured file cabinets located just outside the Control Room.
- Paper sleep records are filed alphabetically after a study has been performed, scored, interpreted and the results uploaded to the patient's electronic medical record (Epic).
- Paper records contain:
  - Sleep Chart Progress Note
  - Copy of final "Sleep Lab Result"
  - PSG Report Card
  - Polysomnogram Technical Report
  - Polysomnogram Documentation Flowsheet
  - Signed patient consent for a sleep study
  - Demographic and Medical Information Questionnaire
  - Pre and Post Evaluation Patient Qustionnaire
  - History and Physical
  - Referral and Approval documentation.
- After interpretation, the sleep laboratory report is uploaded to the patient's electronic medical record by the daytime polysomnographer.
  - Results can be reviewed in Epic by selecting "Results Review" from the activity list
  - Then select "Pulmonary Function" under the All Topics heading
  - The actual report can be viewed as an image once "Sleep Lab Result" is selected and opened

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