

## Guidelines for Copying and Pasting Medical Records

1. Copying information from prior notes may be appropriate when:
  - a. It is based on external sources, such as basic demographic information;
  - b. It is clearly and easily distinguished from the original data entry; or
  - c. It does not become part of the medical record until after undergoing a re-authentication process.
  
2. An author is responsible for the content of their documentation whether it is original or copied & pasted. The author should:
  - a. Review the notes for accuracy, completeness and relevance;
  - b. Ensure that the documentation is in the correct patient's record;
  - c. Confirm that all information has been updated; and,
  - d. Exclude unnecessary or redundant information.
  
3. Proper Use of Copied Information
  - a. Copied information should be brief, selective, and pertinent to the care provided during the current visit.
  - b. Copied text and findings must be integral, relevant and medically necessary to the current encounter.
  - c. Progress notes should provide an accurate description of the treatment provided on a specific date of service.
  
4. Information that should **never** be copied:
  - a. Signature blocks;
  - b. Information from one patient's chart into another patient's chart; or;
  - c. The "History of Present Illness" from an admission should not be repeated in the daily progress notes which should be updated with current information regarding events and changes in a patient's condition.
  
5. Information that may be copied under **very rare** circumstances:
  - a. Verbatim notes on the patient's current condition or plan of care from the previous day; and,
  - b. Physical exam descriptions from a previous day.
  
6. Lab Data, Pathology, Radiology Reports and Other Information
  - a. This information should be reviewed without the author copying them verbatim into their notes.
  - b. Authors should summarize lab data, pathology, radiology reports, and other information.

## 7. Incompatible Data Forms

- a. Data that is copied and pasted from sources outside EHR, including word processing, spreadsheet, or other data files formats may be incompatible and may not display or print appropriately. This includes entry while editing a transcribed document, or direct copy/paste into Epic.
- b. Images including scanned images, photographs, or tables may not be copied and pasted into Epic or transcribed reports. Pasting such data could create storage, printing, release or readability issues.
- c. Forms created using word processing, spreadsheets or other software programs may include special formatting templates that will not view or print properly when pasted into Epic. If a new form is needed, please submit a request for a new form to the Forms Committee.

## 8. Templates, Dot Phrases, and/or Structured Notes

- a. Templates, Dot Phrases, and/or Structured Notes may be used but should be filled out each time without copying from previous notes except where allowed for items that do not change, such as past medical history.
- b. All notes should be accurate and contain current information relevant to the patient's condition and services provided.