POLICY OF STATE OF DELAWARE DEPARTMENT OF CORRECTION	POLICY NUMBER A-08	TOTAL PAGES 6
	RELATED NCCHC / ACA STANDARDS: NCCHC: P-A-08 (essential), J-A-08 (essential), MH-H-01 (essential), O-H-01, O-H-02, O-H-03, O-H-04 ACA: 5-ACI-1E-02, 5-ACI-6A-09, 5-ACI-6C-03 (Mandatory), 5-ACI-6D-05, 5-ACI-6D-06, 5-ACI-6D-07, 4-ALDF-4D-13, 4-ALDF-4D-26, 4-ALDF-4D-27, 4-ALDF-4D-28, 4-ACRS-4C-22, 4-ACRS-4C-23, 4-ACRS-4C-24	
CHAPTER: 11 BUREAU HEALTHCARE, SUBSTANCE ABUSE, AND MENTAL HEALTH SERVICES	**SUBJECT: Health Record**	
APPROVED BY THE BUREAU CHIEF:	**Bureau Chief, Michael Records (signature on file with BHSAMH)**	
APPROVED BY THE COMMISSIONER AND EFFECTIVEDATE	**Acting Commissioner Terra Taylor August 28, 2023 (signature on file with BHSAMH)**	
APPROVED FOR PUBLIC RELEASE		

I. AUTHORITY: 11 *Del. C.* §6536 Medical Care

II. PURPOSE: To standardize the recording of health information of offenders while incarcerated in a Delaware Department of Correction (DDOC) facility; ensure confidentiality of the health record contents and to ensure availability of the record to those with a legitimate need to review the record.

III. APPLICABILITY: All Delaware Department of Correction (DDOC) employees and Contract Provider staff, offenders, and any outside healthcare provider servicing DDOC offenders.

IV. DEFINITIONS: See Glossary

V. SUMMARY OF CHANGES: This policy was updated to include language regarding the timeframe for entering a progress note in the electronic health record.

VI. POLICY:

A. It is the policy of the DDOC that a confidential health record is created and maintained by the DDOC. The DDOC will ensure that the health record uses a standardized format.
   1. The Bureau of Healthcare, Substance Abuse, and Mental Services (BHSAMH) must approve the contents of the EHR and the method for entering information into the EHR. The contents will include, at a minimum, the following:
      a. Identifying information such as name, SBI#, date of birth, gender
      b. A problem list containing medical, dental, and behavioral health diagnoses and treatments as well as known allergies in a prominent location.
      c. Intake screen and health assessment forms

i. Includes initial Medication Assisted Treatment (MAT) health assessment forms.

d. Sick call requests and visits
e. Progress Notes with significant findings, diagnoses, treatments, and dispositions.
    i. Progress Notes shall follow the Subjective – Objective – Assessment – Plan (SOAP) format.
f. Prescriber orders for prescribed medications, list of current medications, and medication administration records.
g. Reports of laboratory and other diagnostic studies
    i. Including laboratory and diagnostic studies related to MAT.
h. Consent for treatment and refusal of treatment forms
i. Consent for Release of Information (ROI) form(s), including documentation to confirm whether the patient is enrolled in community MAT services.
j. Results of specialty consultations and off-site referrals
    i. Should include diagnostic findings as well as treatment recommendations.
k. Offsite discharge summaries
l. Offsite inpatient stays
m. Individual Treatment Plan (ITP)
n. Medical orders
o. Digital dental x-rays
p. Immunization records
q. Telemedicine reports
r. Record of psychological tests administered and dates or administration.
s. Date, time, and place of each clinical encounter
t. Name, title, and credential of each individual documenter.
u. Discharge/release module

2. There shall be separate sections in the EHR for Medical, Dental, and Behavioral Health (includes mental health and substance use disorder (SUD) treatment).
    a. Pertinent information about the offender is shared and within each section of the EHR as needed. This shall include at a minimum, a list of current diagnoses, problems, allergies, and current medications.
3. A health record shall be initiated in the EHR for an offender at the time of intake while conducting the Intake Screening as part of the booking process.
    a. If an offender is readmitted to a facility and they are already in the EHR the record will be reopened and continued.
4. The EHR should allow users to retrieve data by diagnosis, medication, and special needs.
5. All medical order(s) shall be accompanied by an encounter note documenting the reason for the medical order(s).
6. The EHR is maintained in a digitally secure manner in accordance with Delaware Department of Technology and Information (DTI) guidelines and regulations to prevent unauthorized access.
7. The Contracted Medical Provider shall ensure all paper documents generated or received are scanned into the EMR in a timely manner and readily accessible for

viewing to support continuity of care. Rules and guidelines for scanning patient health information are as follows:

a. Day Forward Documents (any paper documents generated or received daily) shall be scanned into the EHR within 24 hrs. of receipt.
b. Urgent/Emergent documents shall be scanned into the EHR immediately upon receipt.
c. Specialty Reports shall be scanned into the EHR within 5 days from the date of the patient consult encounter.
d. Hospital Records shall be scanned into the EHR within 3 days from the date the patient is discharged from the outside medical facility.
e. Staff shall index and perform quality checks prior to scanning and uploading documents into the EHR.
f. Documents that are scanned into the EHR are named in a consistent, easily understood format. The approved list of document titles is attached as Appendix 1.

8. The EHR must be available to health staff and all healthcare encounters are recorded in the EHR.
9. Medication Administration section for the documentation of medications through a medication pass process.
    a. The healthcare staff distributing medications shall document the administration of medication for each offender in the EHR.
10. Healthcare records are kept separate from institutional records.
11. Administrative profiles will be developed by BHSAMH in coordination with DDOC Information Technology (IT).
    a. Permissions will include View Only Add Documentation with Signature.
    b. Change requests for Administrative Profiles for new employees, employees changing positions, or for those leaving employment will be made by the facility HSA to BHSAMH who will notify IT.
    c. Staff working with MAT shall have access to all pertinent sections of the EHR.
12. All healthcare staff receive documented training on the Health Insurance Portability and Accountability Act (HIPAA) and the methods of maintaining confidentiality. This training is repeated periodically in accordance with the DDOC Annual Training Plan.
    a. Offenders' health conditions and treatment progress and/or behavior shall not be disclosed to security staff unless it is necessary and permitted by law and only to the extent required for:
        i. Health and safety of the offender or other individuals,
        ii. Administration and maintenance of the facility,
        iii. Quality improvement relating to healthcare, or
        iv. Law enforcement purposes.
13. If paper medical records are transported by non-healthcare staff, the record is sealed to prevent release of confidential information.
14. When an offender is transferred to another facility, a copy of the medical record accompanies the offender.

a. For patients with critical or chronic health conditions, the health information is flagged to expedite an immediate referral to a qualified healthcare professional at the receiving facility.
b. If an offender is transferred out of state through the Interstate Corrections Compact (ICC) a copy of the health record for the previous year will be prepared and forwarded to the receiving facility.
c. If an offender is transferred out of state through a detainer, the receiving facility must submit an ROI Form (Attachment A) that specifies what records they are requesting. The ROI should be sent to BHSAMH Medical Records Office at DOCMedicalRecords@delaware.gov
d. This transfer complies with all state and federal laws pertaining to confidentiality.

15. All healthcare records will be maintained as determined by the State of Delaware Public Archives Records Retention Policy that can be found at https://archives.delaware.gov/retention
16. Criminal Justice information about an offender that is pertinent to clinical decisions is available to healthcare staff.
    a. This information may include history of violence, drug and/or alcohol use, mental condition at the time of arrest, possession of medication, or in some cases the details of the crime for which they were arrested.

B. Entering a Progress Note in the EHR.
1. To ensure the integrity of the EHR, all documentation of offender encounters and/or treatments shall be completed as soon as possible after the encounter and/or treatment, not to exceed 24 hours, or the next business day.
    a. If the documentation is not entered prior to the end of the shift, the note shall begin with "LATE ENTRY" followed by an explanation as to why the documentation is late, followed by the documentation of the encounter and/or treatment.
    b. At no time should late entries be made after five days have elapsed from completion of the encounter and/or treatment.

C. Removing or Deleting entries in the EHR
1. The EHR shall allow a user to delete a document they placed in the EHR.
    a. Users can only delete a document within 24 hours of the document being uploaded into the EHR.
    b. Documents may only be deleted if they were placed into the EHR in error (e.g., wrong patient document scanned into the wrong file, or incorrect file naming occurred)
    c. Once the document has been deleted, users should be able to see the document listed but the hyperlink for the deleted document should be disabled so the document cannot be opened. The EHR shall maintain a copy of the deleted document which can only be opened and viewed by staff members with a specified profile approved by BHSAMH.
2. The EHR shall allow a user to delete a progress note they placed in the EHR.
    a. Users can only delete a progress note within 24 hours of the progress note being entered into the EHR.
    b. Progress notes may only be deleted if they were entered in the EHR in error (e.g., a note written in the wrong patient's chart, or the note is in the correct chart but contains erroneous information).

c. Once the progress note is deleted, the EHR shall make this progress note viewable, but should appear as greyed out and a single strikethrough line shall be visible indicating that the note was deleted.

3. The EHR shall notify the supervisor of the user who deleted a document or note of the deletion.
4. If it is determined that a document or note should be deleted, and the 24-hour window has expired or the original user is unable to do so, the request shall be sent to BHSAMH for review and approval for deletion. If approved, BHSAMH will coordinate with the EHR IT team to have the document or progress note deleted.

D. In the event of an offender death, no additional information shall be added to the offenders EHR postmortem.
   1. The only exception would be to enter a progress note with a brief summary of the circumstances that led up to the offender's death.
      a. This should include date and time of death and location death occurred.
      b. This note must be entered within 2 hours of notification of the death.

E. There are procedures in place for EHR downtime to include, but not limited to medication administration and sick call processing.
   1. There is documentation of disaster recovery at least once annually and documented verification of backups done on a regular basis.

F. Since the DDOC is utilizing an EHR, all staff must maintain security of computers, tablets, and other electronic devices that may have access to confidential health information in accordance with DTI's Acceptable Use Policy. The locking and/or logging out of a computer is a vital step to ensuring the security of the EHR and offenders confidential health information.

G. Paper records must be marked CONFIDENTIAL and be maintained in a locked cabinet in a locked area to prevent unauthorized access to the record.

H. Offenders may have supervised visual access to their own health record under the direct supervision of a licensed healthcare staff member.
   1. A licensed healthcare staff member must be present to answer any questions the offender may have relating to their record.
   2. The licensed healthcare staff member must maintain control of the keyboard and mouse at all times. The offender may not control or access the computer at any time.
   3. Copies of their health record will not be provided while housed in a DDOC facility unless ordered by a court.
   4. Copies may be obtained by written request by the offender's representative with a properly completed ROI Form (Attachment A).
   5. In accordance with the Privacy Rule §164.524(a)(2)(ii), offenders can be restricted from accessing medical and behavioral health records if there is a therapeutic reason or a safety/security concern to restrict access.
   6. No offender can view, access, or have copies of another offender's health record.

I. All inquiries and complaints from attorneys, family or an advocacy agency that are not part of the Grievance System will be received by, tracked, and answered by the Office of Community Relations based upon information provided by the Medical Services or Behavioral Health Services Contract Providers to the Office of Community Relations.

J. Anyone in DDOC who receives an inquiry from an attorney, family or an advocacy agency relating to an offender's health record shall forward the inquiry to the BHSAMH Medical Records Office at DOCMedicalRecords@delaware.gov with the offender's name in the subject line. The BHSAMH Medical Records Office shall coordinate with the Contract Provider and/or the Office of Community Relations to ensure that a current and properly annotated ROI Form (Attachment A) is on file and will respond to the inquiry within seven (7) business days. If there is no ROI Form signed allowing the inquiring party to receive the information the Contract Provider will ask the offender if they wish to sign an ROI Form releasing the information to the inquiring person.

K. When a request for offender medical records is received, the request is logged in a database maintained by the BHSAMH Medical Records Office and forwarded to the proper facility with a copy to the Medical Services Contract Provider Supervisor of Records. The request will include the offender's name, SBI number and nature of chart copy requested. If part of the record has been archived, the designated BHSAMH records staff will request the chart from Central Archives. Once the completed chart has been obtained, it is forwarded to the requesting party by either State Courier, OMB Messenger Services for USPS mail, fax, or they may be picked up from BHSAMH directly.

    1. Record requests will be responded to with electronic copies only. Medical Records shall be copied onto electronic media by volume number and by tabs within each volume thereby maintaining the chronological order of the record.

L. Charges for records copies

    1. Record requests made by former offenders, Powers of Attorney, private attorneys, or medical facilities other than the Primary Care Physician are chargeable at $.10 per page for a complete set of records and a $3.00 shipping fee. Once records are received from the facility, BHSAMH will calculate the charges and draft an invoice to the requestor. The records are released once payment has been received. A copy of the invoice is kept on file.
    2. If only specific portions of the medical record are requested, an alternative to the $.10 per page is the BHSAMH staff will provide a good faith estimate of how long it will take to find the requested documentation based upon an administrative fee per quarter-hour and $0.10 per page.
    3. Record requests from the Primary Care Physician, Courts, Public Defender Office, Department of Justice, Veteran Affairs, Social Security Administration or any other State or Federal Agencies do not carry a charge.

M. The BHSAMH Records Officer shall be the Bureau Chief of BHSAMH. The Bureau Chief may name other BHSAMH staff as an Authorized Records Agent at his/her discretion.

N. The Contracted Healthcare Provider shall develop within 30 days of the effective date of this policy, a facility-specific procedure for each Level 4 and Level 5 facility implementing this policy and coordinating the procedure with the BHSAMH.

Scanning Form Titles

Titles of documents are to be entered as:
Title Name (noted below in bold print), Document Creation Date or Date of Service, Patient's Last Name and First Initial
(Example: Lab 1.1.18 Doe, J)

INTAKE	IMMUNIZATION TAB
Intake Sign - Intake Screening Signature Sheet	**TB & Vaccine-** Tuberculosis & Immunization Form
Intake Pack - Intake Documents Group Scanning includes: **Intake Sign, ROI DHIN, Condition Admit, Patient Edu, Svcs Consent, Travel Related Screening, Prescreening Tool**	**DE Immun Rec** - State of Delaware Division of Public Health Immunization Records
Condition Admit - Booking and Receiving Condition on Admission (BWCI Form)	**Flu Consent** - Flu Consent
Periodic Assess - Periodic Health Assessment	**FLU Pack** - Flu vaccine documents Group Scanning: Influenza Vaccine of Consent, ILI or Prescreening Tool, FLU Orders
H & P - Medical History & Physical Assessment	**Hep. A Consent** - Hepatitis A Consent
Med Trans Sign - Medical Transfer Signature Form	**Hep. B Consent** - Hepatitis B Consent
Transfer Pack - Med Transfer Document Group Scanning includes: **Med Transfer Sign, Prescreening Tool, Svcs Consent, Patient Edu, ROI DHIN**	**Hep. A & B Consent** - Hepatitis A & B Consent
Med Screening - Medical Screening Form	**ILI -** Influenza-Like-Illness or Pre-screening Tool
Med Clearance - Medical Clearance	**Influenza Record** - Influenza Vaccination Administration Record
Preventive Exam - Preventive Exam	**Pneumovac Consent** - Pneumovac Consent
Med Clearance - Medical Clearance	**Prescreeing Tool -** Prescreening Tool
Pre-Seg Assess - Pre-Segregation Health Assessment	**Refusal FLU** - Refusal of Treatment FLU
Intake Meds Receipt - Intake Medication Receipt	**Refusal FLU Docs -** Refusal of Consent, ILI or Prescreening Tool
Transfer Sign - Inter-System Transfer Signature	**Shingle Consent** - Shingle Consent
	TB Declaration - Tuberlosis Declaration of Symptoms
ADVANCE DIRECTIVE	**Tdap Vaccine** - Tetanus, Diphtheria, Pertusis Vaccine Consent Form
MOLST - Advance Directive	**Tetanus Consent** - Tetanus Consent
	Travel Related Screening - Emerging and Travel-Related Infectious Disease Screening Tool

OUTPATIENT RECORDS TAB	SICK CALL TAB
DHIN Records - DHIN Community Health Records	**NSC Med** -Sick Call Medical
Out Med Info - Outside Medical Information	**NSC Pharm** - NSC Pharmacy
DHIN - Delaware Health Information Network **(Medication)**	**SC HIV/STD** - Sick Call HIV/STD Testing
Out Transfer - Any Out of State Correctional Incarceration Documentation	**NSC, Fee** - Nurse Sick Call Slip, Fee Sheet
	Nursing Protocol - Nursing Protocol
OB/GYN	
OB Edu. List - Obstetric Checklist Patient Education	**PROGRESS NOTES**
Antepartum Rec - Antepartum Record	**Referral Nursing** - Staff Referral Nursing
GYN Pap Smear - GYN Pap Smear	**Referral MLP -** Staff Referral Mid Level Provider
Referral OB GYN - Staff Referral OB-GYN	**Referral Physician -** Staff Referral Physician
Maternal Fetal Consult - Delaware Center of Maternal & Fetal Medicine	**Patient Edu** - Patient Education Sheet
Urinalysis Results - Urinalysis Test Results or Urine Pregnancy Test	**Med Report Injury** - Medical Report on Injuries/Non-juries
Condition Admit - Booking and Receiving Condition on Admission BWCI Form)	**SC MLP** - Sick Call Mid-Level Provider
Cytology Report - Cytology Report	
	CHRONIC CARE TAB
	CC Clinic FU - Chronic Disease Clinic Follow-up
	C Counsel RES- Community Counseling Resources
DISCHARGE PLANNING TAB	**CC Enroll -** Chronic Care Enrollment Form
Jail MH Screen - Brief Jail Mental Health Screening	**CC Other Int. Visit -** Chronic Care - Other Initial Visit
Uncope Screen - Uncope Screening	**CC Periodic FU** - Chronic Care Periodic Exam Follow-up
Inter. Clin. Status - Interagency Clinical Status Information	**CC Referral** - Chronic Care Staff Referral
Release Meds Hand- Discharge Medication Handling Upon Release Acknowledgement Form	**CC Seizure Initial** - Chronic Care Seizure Initial Visit

Sup. Court MH Meds Transfer - Superior Court of Delaware MH Medication Transfer Worksheet	**CID** - Chronic Infection Disease Referral
Release Confidential -Authorization for Release of Confidential Information	**CID Referral - Chronic Infection Disease Nurse Referral**
	Foot Exam - Comprehensive Diabetes Foot Exam
	HIV Post Test Counsel - HIV Post Testing Counsel Form
DISCHARGE/RELEASE MODULE	**Neuro Assess** - Neurological Assessment Sheet
BCHS DC Plan - BCHS Discharge Plan	**Pain Assess Scale -** Objective Pain Assessment Scale CorrectRx Pharmacy Services
DC Reentry Summary - Discharge Reentry Summary	**Treat Plan** - Treatment Plan
DC Release Plan - Discharge/Release Plan	
DC Meds Receipt - Discharge Medication(s) Receipt	**PSYCH TAB**
DC Needs Questionnaire - Reentry Needs Questionnaire	**24 Hour ER Admit** - 24 Hour Emergency Admission
DC Plan Meds Req - Discharge Planning Medication Request	**Abnormal Move Scale** - Abnormal Involuntary Movement Scale (Modified)
	Appt. Treat Review - Appointment of Treatment Review Committee
FLOWSHEET TAB	**Auth Comm. MH ROI** - Authorization for Release of Community Mental Health Information
CD4 Viral Flow - CD4/Viral Load Flow Sheet	**Auth MH ROI** Medical Record - Authorization for Release of Mental Health Information in Medical Record
CIWA Perform - CIWA Performance Sheet ETOH	**CAGE Tool** - Cage Substance Abuse Screening Tool
CIWA SS- CIWA-Ar Score Sheet	**C Counsel RES** - Community Counseling Resources
COW SS Opiate - COW Score Sheet for Opiate Withdrawal	**Consent Antipsy Meds** - Informed Consent of Antipsychotic Medication
Daily Wt & BP Log - Daily Weight and Blood Pressure Log	**Consent Lithium** - Informed Consent of Lithium
Daily Treat Rec- Daily Treatment Record	**Consent MH Meds** - Informed Consent of (MH) Medication
Hunger Strike Log - Food/Vital Sign Monitoring Hunger Strike	**EEU** - Eligibility & Enrollment Form
MH Observe Monitor - Mental Health Observation Monitoring	**INT MH Seg. Assess** - Initial Mental Health Segregation Assessment
Seg. Rec Log - Segregation Record Review and Visit Log	**INT Psy Eval** - Initial Psychiatric Evaluation
Skin Wound Assess- Wound Skin Ongoing Assessment	**MH Counsel Svcs** - Delaware Mental Health Counseling Services
Therapeutic Restraint - Therapeutic Restraint Flow Sheet	**MH Inmate RES** - Mental Health Inmate Written Response Form
Wound Care Flow - Wound Care Flowsheet	**MH Level Sheet -** Mental Health/Psychiatry Observation Level Sheet
Narc Dose Log - Narcotic Medication Dose Log	**MH Referral -** Mental Health Referral

OUTPATIENT CONSULT TAB	**MH Rev Discipl** - Mental Health Review Disciplinary Charges
	MH Treat Plan - Mental Health Treatment Plan
Cardio Cons - Consult Sheet for Cardiology	**NSC MH** - Sick Call Mental Health
Completed Consult- Completed Consultation Form	**Psy Meds Consent** - Psychotropic Medication Consent Form
Derm Cons- Consult Sheet for Dermatology	**Psy Observe Daily Note** - Psychiatric Observation Note: Daily Contact
ER Inpt. Referral - Emergency Room/Inpatient Referral Form	**Psy Progress Note** - Psychiatric Progress Note
ER Visit - Emergency Room Visit	**Psych Inpt. Referral** - Psychiatric Inpatient Referral
Gastro Cons - Consult Sheet for Gastroenterology	**Referral Spec Needs Unit** - Special Needs Unit Referral
Hemo Cons- Consult Sheet for Hematology	**Refusal MH -** Refusal Mental Health
Man Down - Man Down Response Form	**Release Responsibility** - Delaware DOC Release of Responsibility
Nephro Cons - Consult Sheet for Nephrology	**Suicide Assess** - Suicide Self Injury Risk Assessment
Neuro Cons - Consult Sheet for Neurology	**Suicide Risk Assess -** Suicide Risk Assessment
Offsite DC Summary - Offsite Discharge Summary	**TRC -** Treatment Review Committee Report
Offsite Med Record - Offsite Medical Records	
Offsite Return - Offsite Return Progress Note	
Oph Cons- Consult Sheet for Ophthalmology	**MAR TAB**
Ortho Cons- Consult Sheet for Orthopedic	**Diabetic Flow** - Diabetic Flowsheet
Outpt. Referral Req - Outpatient Referral Request Form	**KOP** - Keep on Person Medication Record or Self Medication MAR
Pod Cons - Consult Sheet for Podiatry	**Insulin Admin Rec** - Insulin Administration Record
Surg Cons - Consult Sheet for Surgeon	**MAR** - Medication Administration Record
Urol Cons - Consult Sheet for Urology	**Meds Missed or Refused** - Medications Missed/Refused Times 3 Day Form
	Non-Prefer Meds Req - Non-Preferred Medication Request
	Diabetic Treatment - Diabetic Treatment
CONSENTS TAB	**Prescription Slip** - Outside Provider Medication Prescription Slip
Allergies Diet - Allergies Diet	**Refusal Meds** - Refusal of Treatment (**Medication Only**)
Consent Treatment - Consent of Treatment	**Specific Meds Admin Log - (No title on form)** Specific Medication Administration Log
Consent Test HIV - Consent to Test for HIV Antibody	
Informed Consent - Informed Consent	
Meds Verification - Medication Verification/Medical Release	
Nutrition Assess - Nutrition Assessment/Reassessment	

Refusal Other - Refusal of Treatment "Other" noted	
Refusal Outside Appt - Refusal Outside Medical Appointments	**LAB/X-RAY TAB**
Refusal Other Diagnostic - Refusal of Other Diagnostic Services	**CT Angiogram** - CT Angiogram
Refusal Phy Exam - Refusal of Physical Exam	**CT (Add Type)** - CT - (Example: CT Brain,)
Refusal Specific Svcs -Refusal of Other Specific Services	**Colorguard** - Cologuard Patient Report
Svcs Consent - Medical, MH, Vision Consent - Medical, Mental Health, Vision Care Consent	**Cytology Report** - Cytology Report
Informed Meds Assist Withdrawal - Informed Consent for Medication-Assisted Withdrawal	**DHSS Lab Req** - Delaware Health and Social Services Laboratory Request Form
	Diagnostic Report - Quest Diagnostic Report
	Echo - Echocardiogram
***SPECIAL NEEDS NOTE TAB**	**Lab** - Lab Report
Spec Needs Note - Special Needs Note	**Lab or X-RAY Result** - Notification to Patient of Laboratory Test Result
	Spirometry - Spriometry Test
***PROBLEM LIST TAB**	**MRI** - Magnetic Resonance imaging Report
Problem List	**Urine Dipstick** - Urinalysis Dipstick Results
	"Specific Type" X-ray - "Example- Chest, Right Arm, Head, etc." X-ray Report
	Ultrasound - Ultrasound Report
	Urine Dipstick - Urinalysis Dipstick Results
PHYSICIAN ORDER TAB	
Formulary Except - Formulary Exception Request	
FLU Order - Standing Order: Influenza Vaccine	**DENTAL TAB**
Inf. Admit Order Set - Infirmary Admission Order Set	**Den Referral -** Staff Referral Dental
Lab or Imaging or EKG or Urine Order - Lab/Imaging Order	**NSC Den -** Sick Call Dental
Narcotic Order - Narcotic Order Form	**Den Exam -** Dental Exam
Physician Order - Physician Order	**Denture Agreement** - Denture Agreement
Provider Admit Order - DOC Provider Admission Order	**Consent Extract** - Informed Consent for Extraction of Teeth
	Refusal Den- Refusal of Treatment Dental

INFIRMARY TAB	MISC TAB
Care Plan - Care Plan	**Eye Script Order** - Eyeglass Prescription Order Form
Daily Inf. Care - Daily Infirmary Care Record	**Eye Record** - Eye Record
Inf. Admit Record- Infirmary Admission Record	**Eye Script** - Eye Script
Inf. Progress Note - Infirmary Progress Note	**Incident Report** - Incident Report
Intake Output- Intake Output Flowsheet	**Hospice Notes** - Hospice Notes
Nursing Assess - Nursing Assessment	**Med Memo Request** - Medical Memorandum Request to Security
Provider Inf. Admit- Provider Infirmary Admission	**Memo** - Memo Form
Provider DC Summary- Provider Infirmary Discharge Summary	**Memo Temporary** - Memo Temporary Restriction
	Receipt Med Product - Receipt for Medical Product
	Receipt Med Propty - Receipt for Medical Property
	Spec Meds Accom - BWCI Special Medical Accommodations Memo
	Spec Needs Referral - Special Needs Referral Form
	Spec Needs Comm. - Special Needs Communication Form
*** All Tabs are highlighted in "Yellow" and New Tab Titles are noted in "Red" with Yellow highlight**	*** Any additional forms received after release will be scanned to this tab. If pertaining form tab is not available**