Professional Practice Standard: Companion Animal Medical Records[1]

Published December 2017

This College publication describes a mandatory standard of practice. The *Veterinarians Act* in section 52 provides that a failure to comply with a standard may be investigated.

This practice standard should be read together with "Professional Practice Standard: Medical Record Keeping".

Synopsis

1. General Principles of medical record keeping:
   a. legibly written or typewritten.
   b. organized in a systematic manner.
   c. If there is more than one Registrant practicing at a facility, entries must be initialed or otherwise marked for attribution of authorship.
   d. Modifications, explanations or clarifications after the initial consultation or examination should be clearly identified as addenda and dated separately.

2. Specific requirements:
   a. On each page of the report:
      i. Client identification, including first and last name, address and phone numbers; when applicable, an alternative contact's name and phone number in case the client cannot be contacted in an emergency.
      ii. Patient identification, including species, breed, colour, date of birth (can be approximate), and gender, and any identification marks, microchip or tattoo.
   b. Health records from previous veterinarians, including a record of vaccinations.
   c. The date of each consultation or examination.
   d. The animal's current weight (on the date of each visit or assessment)
   e. For each physical and behavioural assessment:
      i. A reasonably detailed history of the complaint.
      ii. Physical examination findings or behavioural assessments, including both normal and abnormal findings.

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[1] Council approved the 'Professional Practice Standard: Companion Animal Medical Records' on June 17, 2017. It is available on the CVBC website (www.cvbc.ca) under Resources > Bylaws, Standards & Policies.

iii. An overall assessment of the case that includes a tentative diagnosis and a list of differential diagnoses (or a definitive diagnosis, if confirmed).
iv. Specifics of diagnostic investigations performed or ordered.
v. A written treatment plan that provides the level of detail necessary for a colleague to understand the direction of the case at the time of writing.
vi. Results of the diagnostic investigations performed and an interpretation of the results.
vii. The date and (approximate) time of each client communication, the name of the person communicated with, and a summary of the exchange.
viii. Any additional pertinent information.

f. All medical and surgical treatments and procedures used, dispensed, prescribed, or performed by or at the direction of the Registrant, including the name (brand name if applicable or generic drug name), strength, dose, and quantity of any drugs.
g. Consent for all surgical and dental treatments:
   i. Written consent to the surgical or dental treatment signed by or on behalf of the owner of the animal, or
   ii. A note that the owner of the animal or person on the owner's behalf (owner's agent) consented orally to the surgical or dental treatment, and the reason why the consent is not in writing, or
   iii. A note that neither the owner nor the owner's agent was available to consent to the surgical or dental treatment and the reason why, in the Registrant's opinion, it was medically advisable to conduct the surgical treatment.
h. A copy of all reports prepared by the Registrant in respect of the animal, including:
   i. Estimates for proposed services,
   ii. Diagnostic text reports, and
   iii. Itemized fees and charges.

Guide to the Professional Practice Standard

A separate Guide to the Professional Practice Standard: Medical Record Keeping that includes 'Frequently Asked Questions' can be found on the College's website at www.cvbc.ca.

Acknowledgement

Adapted with permission from the CVO's "Professional Practice Standard Medical Records".