College of Veterinarians of British Columbia

Professional Practice Standard: Equine Medical Records[1]

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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 not recorded at the time of the consultation or examination should be clearly identified as addenda and dated separately.

2. Specific requirements for equine records:
   a. On each sequentially dated and/or numbered page, the patient name (or i.d. number) and the client name (or file number).
   b. 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, is recommended. Ownership/co-ownership should be clearly noted.
   c. Patient identification, including (but not limited to) species, breed, colour, date of birth (can be approximate), and gender.
   d. The date of each consultation or examination.
   e. Estimated body weight, score on Body Condition Scale, and note of any visible or measurable body weight change of the patient
   f. For each physical and behavioural assessment:
      i. A reasonably detailed history of the complaint.

[1] Council approved the 'Professional Practice Standard: Equine Medical Records' on May 4, 2018. It is available on the CVBC website (www.cvbc.ca) under Resources > Legislation, Standards & Policies.

ii. Physical examination findings or behavioural assessments, including both normal and abnormal findings.
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 any diagnostic investigations performed or ordered, as well as the results and registrant's interpretations of such investigations.
v. A written treatment plan that provides the level of detail necessary for a colleague to understand the direction of the case.
vi. The date of client communications involving substantive matters, the name of the person communicated with, and a summary of the exchange.
vii. Any additional pertinent information.

g. 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.
h. A copy of all reports prepared by the Registrant in respect of the animal, including but not limited to:
    i. Estimates for proposed services (if used),
    ii. Diagnostic test reports, and
    iii. Itemized fees and charges.
i. Written Consent for euthanasia is recommended to be signed by the owner. Alternatively, if consent is verbal it must be documented by the Registrant.

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.