

**TITLE 310. OKLAHOMA STATE DEPARTMENT OF HEALTH  
CHAPTER 667. HOSPITAL STANDARDS**

**Subchapter 19 - Medical Records Department**

**310:667-19-2. Reports and records**

(a) Reports shall be made by each hospital to the appropriate agency, including but not limited to the following:

- (1) Communicable disease.
- (2) Births and deaths.
- (3) Periodic reports to the Department on forms supplied for this purpose.
- (4) Newborn hearing screening report.

(A) All hospital nurseries shall complete a newborn hearing screening report form on all live newborns discharged from their facility. For facilities with a two-year average annual birth census of 15 or greater, physiologic hearing screening results as well as "at risk" indicators must be recorded on the report form; for facilities with a two-year average annual birth census of fewer than 15, "at risk" indicators must be recorded and if physiologic hearing screening is conducted, those results also must be recorded on the report form. It shall be the responsibility of the hospital administrator to assure that the Newborn Hearing Screening Report Form is correctly completed and subsequently submitted to the Department. The hospital administrator may designate one individual, who shall then be responsible for review of all newborn discharge summaries to insure that a report form has been completed for each infant and that the report form is a permanent part of that infant's record. A copy of the hearing screening report form must be given to the infant's caregiver at discharge.

(B) If an infant is transferred from one hospital to another, the second hospital shall be responsible for providing physiologic hearing screening, "risk indicator" screening, and for completion of the report form.

(C) It shall be the responsibility of the hospital administrator to insure that all completed report forms are mailed to the Department within seven (7) days of an infant's birth.

(D) It shall be the responsibility of the attending physician or licensed independent practitioner to inform parents if their infant passed or was referred on the physiologic hearing screening and/or if the infant is to be considered "at risk" for hearing impairment. Prior to discharge, the attending physician or licensed independent practitioner shall review the completed report form and shall inform the parents of their infant's status. Infants who do not pass the physiologic screening shall be referred for a diagnostic audiological evaluation as soon as possible.

(E) It shall be the responsibility of the coordinator of the Newborn Hearing Screening Program at the Department to arrange for hospital in-service training for all hospital personnel involved

in the process of completion of report forms. A manual of procedures shall be available in regard to processing of screening forms. The literature for distribution to parents shall be available from the Department.

(5) Newborn metabolic disorder screening.

(A) **Testing of newborns.** All newborns in Oklahoma shall be tested for phenylketonuria, hypothyroidism, galactosemia and sickle cell diseases ~~by a Certified Newborn Metabolic Disorder Screening Laboratory as defined in Chapter 550 of this Title,~~ cystic fibrosis, congenital adrenal hyperplasia, medium-chain acyl coenzyme A dehydrogenase deficiency (MCAD), biotinidase deficiency, amino acid disorders, fatty acid oxidation disorders, organic acid disorders, and upon completion of laboratory validation studies and establishment of short-term follow-up services, Severe Combined Immunodeficiency (SCID) detectable via the Department's laboratory technology utilized in newborn screening and approved by the Commissioner of Health as defined in Chapter 550 of this Title. All infants born at a birthing facility in Oklahoma shall be screened for Critical Congenital Heart Disease (CCHD) utilizing pulse oximetry. ~~a~~<sup>a</sup> parent or guardian may refuse metabolic disorder newborn screening and/or pulse oximetry screening of their newborn on the grounds that such examination conflicts with their religious tenets and practices. A parent or guardian who refuses metabolic disorder newborn screening or pulse oximetry screening of their newborn on the grounds that such examination conflicts with their religious tenets and practices shall also indicate in writing this refusal in the newborn's medical record with a copy sent to the Newborn ~~Metabolic Disorder Screening Program, Maternal and Child Health Prevention and Preparedness Service~~<sup>Services</sup>, Oklahoma State Department of Health, 1000 NE Tenth Street, Oklahoma City, Oklahoma 73117-1299.

(B) **Specimen collection for hospital births.** For all live hospital births, the physician or licensed independent practitioner shall order the collection of a newborn ~~metabolic disorder~~ screening specimen on all newborns prior to transfusion, ~~at three to five days of age as early as possible after 24 hours of age~~ or immediately prior to discharge, whichever comes first. Specimens shall be collected on the Newborn ~~Metabolic Disorder Screening Form Kit~~ as described in Appendix A of Chapter 550 of this Title using capillary or venous blood. Cord blood is unacceptable. The hospital is responsible for collecting specimens on all infants.

(i) If the initial specimen for any infant is collected prior to 24 hours of age, the hospital and the physician or licensed independent practitioner are responsible for notifying the infant's parents that a repeat specimen is necessary at three to five days of age. The infant's physician or licensed independent practitioner is responsible for insuring that the repeat specimen is collected.

(ii) The hospital is responsible for submitting a satisfactory

specimen and for documenting all requested information on the form kit including the parent/guardian's name, address, phone or contact phone number and the planned health care provider who will be providing well care for the infant after discharge, or if the infant is to be hospitalized for an extended period of time, the name of the infant's physician or licensed independent practitioner.

(iii) The hospital is responsible for documenting specimen collection and results in the infant's hospital record.

(iv) Infants transferred from one hospital to another during the newborn period shall have specimen collection documented in the infant's hospital record. It is the responsibility of the physician or licensed independent practitioner and the receiving hospital to insure a specimen is collected.

(v) It is the responsibility of the hospital and physician or licensed independent practitioner to insure that all infants are screened prior to discharge. If an infant is discharged prior to specimen collection, the ~~Newborn Metabolic Disorder~~ Screening Program Coordinator shall be notified by contacting ~~Maternal and Child Health~~ Newborn Screening Program, Prevention and Preparedness Service Services, Oklahoma State Department of Health, 1000 NE Tenth Street, Oklahoma City, Oklahoma 73117-1299, (405) 271-6617, FAX (405) 271-4892, 1-800-766-2223, ext. 6617. The physician or licensed independent practitioner is responsible for insuring the specimen is collected ~~at three to five days of age~~ as early as possible after 24 hours of age.

(C) **Pulse oximetry screening for birthing hospitals.** For all live hospital births, the physician or licensed independent practitioner shall order the pulse oximetry screening for newborns to be performed after 24 hours of age or prior to discharge from a facility.

(i) If unable to perform the screening after 24 hours of age or prior to discharge, schedule the infant to be screened at the hospital between 24 hours and 48 hours of life; or notify the infant's physician if screening was not performed.

(ii) If the newborn infant is discharged from a facility after 12 hours of life but before 24 hours of life, the birthing facility shall perform screening as late as is practical before the newborn infant is discharged from the birthing facility.

(iii) If the infant is discharged before 12 hours of life, the birthing facility shall perform the screening between 24 hours and 48 hours of life.

(iv) For newborn infants in special care or intensive care, birthing facilities shall perform pulse oximetry screen on infants prior to discharge utilizing recommended protocol, unless the infant has an identified congenital heart defect or has an echocardiogram performed. Continuous pulse oximetry monitoring may not be substituted for CCHD screening.

(v) There may be instances where screening for CCHD is not indicated, including but not limited to instances where:

(I) The newborn infant's clinical evaluation to date has included an echocardiogram which ruled out CCHD; or

(II) The newborn infant has confirmed CCHD based on prenatal or postnatal testing.

(III) Indicate on NBS filter paper that screening was not performed.

**(D) Screening for premature/sick infants.** For all premature/sick infants, the physician or licensed independent practitioner shall order the collection of a newborn ~~metabolic disorder~~ screening specimen prior to red blood cell transfusion, ~~at three to seven days of age~~ as early as possible after 24 hours of age, or immediately prior to discharge, whichever comes first. It is recommended that a repeat newborn ~~metabolic disorder~~ screening specimen be collected at 14 days of age. Specimens shall be collected on the Newborn ~~Metabolic Disorder~~ Screening Form Kit using capillary or venous blood. The hospital is responsible for collecting specimens on all premature/sick infants.

(i) Premature/sick infants screened prior to 24 hours of age must be re-screened between 7-14 days of age.

(ii) Premature/sick infants who could not be screened prior to a red blood cell transfusion should be re-screened by the 7th day of life and a repeat specimen collected when plasma and/or red cells will again reflect the infant's own metabolic processes or phenotype. The accepted time period to determine hemoglobin type is 90 to 120 days after transfusion.

(iii) The recommended follow-up study for an abnormal thyroid screen in a premature infant is a serum free T4 (measured by direct dialysis or an equivalent method) and TSH at 7-14 days of age.

~~(D)~~ **(E) Newborn Screening Hospital recording.** The hospital shall implement a procedure to assure that a newborn screening specimen has been collected on every newborn and mailed to the Newborn ~~Metabolic Disorder~~ Screening Laboratory within 24 - 48 hours of collection.

(i) The hospital shall immediately notify the infant's physician or licensed independent practitioner, and parents or guardians if an infant is discharged without a sample having been collected. This notification shall be documented in the infant's hospital record.

(ii) If no test results are received within fifteen (15) days after the date of collection, the hospital shall contact the Newborn Metabolic Disorder Screening Laboratory to verify that a specimen had been received. If no specimen has been received, the hospital shall notify the physician or licensed independent practitioner.

(iii) Any hospital or any other laboratory which collects, handles or forwards newborn ~~metabolic disorder~~ screening samples shall keep a log containing name and date of birth of the infant, name of the attending physician or licensed independent practitioner, name of the health care provider who will be

providing well care for the infant after discharge, medical record number, serial number of the form kit used, date the specimen was drawn, date the specimen was forwarded, date the test results were received and the test results, and pulse oximetry screening results.

~~(iv) The hospital is responsible for assuring that employees who collect, handle or perform newborn metabolic screening tests are informed of their responsibilities with respect to screening procedures.~~

**(F) Pulse oximetry screening hospital recording.** The hospital shall implement a procedure to assure that pulse oximetry screening has been performed on every newborn prior to discharge.

(i) All pulse oximetry screening results shall be recorded in the newborn infant's medical record and results reported to a parent or guardian prior to discharge from the hospital.

(ii) All pulse oximetry screening results shall be recorded on the Newborn Screening Collection Kit (ODH #450), as described in Appendix A of Chapter 550 of this Title, or faxed to the Oklahoma State Department of Health Newborn Screening Program.

~~(E)~~ **(G) Parent and health care provider education.** The hospital will be responsible or designate a responsible party to distribute the Newborn ~~Metabolic Disorder~~ Screening Program's written educational materials on newborn ~~metabolic disorder~~ screening and pulse oximetry screening provided by the Department to at least one of each newborn's parent or legal guardian.

~~(F)~~ **(H) Training.** Hospitals shall provide ongoing training programs for their employees involved with newborn screening procedures. These training programs shall include methods of collecting a ~~Ssatisfactory Nnewborn Metabolic Disorder Sscreening Sspecimen-~~ and proper pulse oximetry screening methods. The hospital is responsible for ensuring that employees who collect, handle or perform newborn screening tests; or perform pulse oximetry screening are informed of their responsibilities with respect to screening procedures.

(6) Birth defects. Each hospital shall maintain a list of patients up to six (6) years of age who have been diagnosed with birth defects, and all women discharged with a diagnosis of stillbirth or miscarriage. On request, each hospital shall make the medical records of these individuals available to the State Department of Health.

(7) Abortions. Attending physicians shall complete and submit to the Department a report form for each abortion performed or induced as required by 63 O.S. 1999, Section 1-738.

(b) **Record of patient admission.**

(1) All persons admitted to any institution covered by these standards shall be under the care of a doctor of medicine (M.D.) or osteopathy (D.O.) duly licensed to practice medicine and surgery in the State of Oklahoma or a licensed independent practitioner, whose name shall be shown on the admitting record.

(2) The hospital admitting record also shall show the following for each patient.

- (A) Full name of patient with age, sex, address, marital status, birth date, home phone number, date of admission, and admitting diagnosis.
  - (B) Next of kin, with address, phone number, and relationship.
  - (C) Date and time of admission, the admission and final diagnoses, and the name of physician or licensed independent practitioner.
  - (D) Any advanced directive for health care as defined in the Oklahoma Rights of the Terminally Ill or Persistently Unconscious Act.
- (3) Special clinical reports shall be kept, including the following:
- (A) Obstetrical patients throughout labor, delivery, and post-partum.
  - (B) Newborn, giving the infant's weight, length, and other notes relative to physical examination.
  - (C) Surgical and operative procedures, including pathological reports.
  - (D) Record of anesthesia administration.
- (c) **Orders for medications, treatments, and tests.**
- (1) All medication orders shall be written in ink and signed by the ordering physician or practitioner authorized by law to order the medication, with the exception of influenza and pneumococcal polysaccharide vaccines, which may be administered per physician-approved hospital policy after an assessment for contraindications. The order shall be preserved on the patient's chart.
  - (2) All orders shall be written in ink and signed by the ordering physician or practitioner. Orders received by resident physicians shall be co-signed if required by medical staff bylaws. The order shall be preserved on the patient's chart.
  - (3) All orders taken from the physician or practitioner, for entry by persons other than the physician or practitioner, shall be countersigned.
  - (4) Telephone or verbal orders may be authenticated by an authorized physician or practitioner other than the ordering physician or practitioner when this practice is defined and approved in the medical staff bylaws. If allowed, medical staff bylaws must identify the physicians or practitioners who may authenticate another physician's or practitioner's telephone or verbal order, e.g. physician partners or attending physicians or practitioners, and define the circumstances under which this practice is allowed. The bylaws must also specify that when a covering or attending physician or practitioner authenticates the ordering physician's or practitioner's telephone or verbal order, such an authentication indicates that the covering or attending physician or practitioner assumes responsibility for his or her colleague's order and verifies the order is complete, accurate, appropriate, and final. The person taking the telephone or verbal order shall read the order back to the physician or practitioner to ensure it was correctly understood and verify on the order the fact that the order was read back. Each facility, within its own procedures and protocols, shall establish a verification process to be placed on orders to demonstrate that the order was read back to the physician.