



Patient Information Retention and Disposal Schedule

Version 4, 2014

**Disposal Authority RD 2014001
Approved by the State Records
Commission of Western Australia**

Contents

Acknowledgements	30
Abbreviations	31
Section 1 Introduction	32
1 About this document.....	32
1.1 Background	32
1.2 Purpose of the Patient Information Retention and Disposal Schedule	32
1.3 Scope of the Patient Information Retention and Disposal Schedule.....	32
1.4 Revision of the Patient Information Retention and Disposal Schedule	33
2 Recordkeeping environment	34
2.1 Legislation	34
2.2 General disposal authorities	34
2.3 Freedom of information.....	34
2.4 Investigations and inquiries	35
2.5 Cessation of authority.....	35
3 Western Australian health records	35
3.1 Formats	35
3.2 State archives.....	37
3.3 Temporary record.....	37
3.4 Restricted access archives.....	37
3.5 Archives not transferred to the State Records Office of Western Australia.....	38
3.6 Retention of records relating to Aboriginal people	39
3.7 Psychiatric patient records.....	40
3.8 Obstetric records	40
3.9 Case Management Program records.....	41
3.10 Reproduction of records	41
4 Western Australian Health recordkeeping practices.....	42
4.1 Date of last access	42
4.2 Sentencing.....	43
4.3 Storage	43
4.4 Disposal of State records.....	44
4.5 Significance of records	45
4.6 Recommended methods of disposal	46
4.7 Destruction register for all record formats.....	48

5	Arrangement and definitions of terms used in the Patient Information Retention and Disposal Schedule.....	49
5.1	Arrangement.....	49
5.2	Definitions.....	49
Section 2	Schedule notes.....	28
1	Individual patient records – acute hospitals.....	28
2	Inpatient records – extended care facilities	34
3	Non-inpatient records – extended care facilities.....	35
4	Documents relating to legal claim.....	36
5	Special categories of individual patient records	37
6	Community health records	43
7	Dental records.....	55
8	Microform documents.....	56
9	Patient indexes, registers and lists.....	58
10	Summarised and ephemeral documentation	68
11	Pathology, laboratory records and diagnostic material	70
12	Drug records	86
13	Imaging records	89
14	Statutory notifications of births and deaths	93
15	Statutory health reports.....	95
Section 3	Appendices.....	98
	Appendix 1 – WA Health districts and remoteness.....	98
	Appendix 2 – Decision flow charts for records.....	99
	Appendix 3 – Record destruction register.....	106

Acknowledgements

The *Patient Information Retention and Disposal Schedule Version 4, 2014* (Schedule) was developed and prepared by the Resourcing and Performance Division, Department of Health.

Thanks and appreciation is extended to Legal and Legislative Services, Department of Health and the State Records Office of Western Australia for their advice and guidance.

Thanks are also extended to those individuals who provided advice, feedback and comments during the development of the Schedule.

Abbreviations

The following abbreviations are used throughout the Schedule:

AI	Artificial Insemination
AIDS	Acquired Immune Deficiency Syndrome
CHS	Community Health Service
CMP	Case Management Program
CPI	Central Patient Index
CT	Computerised Tomography
CTG	Cardiotocogram
DPR	Digitised Patient Record
ECG	Electrocardiogram
ECT	Electroconvulsive Therapy
EEG	Electroencephalogram
EMG	Electromyogram
GDA	General Disposal Authority
HCARe	Health Care and Related Information Systems
HSP	Health Service Provider
HIV	Human Immunodeficiency Virus
IT	Information Technology
IVF	In-Vitro Fertilisation
MR	Medical Record
MRI	Magnetic Resonance Imaging
NHMRC	National Health and Medical Research Council
NPAAC	National Pathology Accreditation Advisory Council
PMI	Patient Master Index
SRC	State Records Commission of Western Australia
SRO	State Records Office of Western Australia
TOPAS	The Open Patient Administration System
UMRN	Unit Medical Record Number
WA	Western Australia
webPAS	Web Patient Administration System

Section 1 Introduction

1 About this document

1.1 Background

Western Australian Health is the public health system of Western Australia (WA) which provides safe, high-quality health care to nearly 2.6 million people in the State. WA Health is comprised of the Department of Health, Health Service Providers (North, South, WA Country, Child and Adolescent and East Metropolitan Health Services, as well as the Quadriplegic Centre and Hospital Support Services), and Contracted Health Entities.

WA Health is reliant on access to relevant and accurate patient medical records for the effective delivery of patient care. This information underpins the delivery of evidence-based health care. Information has most value when it is accurate, up-to-date and accessible when it is needed. An effective records management service ensures that information is properly managed and is available whenever and wherever there is a justified need for that information, and in whatever media it is required.

An important part of an effective records management service is determining how long to retain information relating to patients. A retention and disposal schedule ensures records are kept for as long as legally and operationally required and that obsolete records are disposed of in a systematic and controlled way.

1.2 Purpose of the Patient Information Retention and Disposal Schedule

The *Patient Information Retention and Disposal Schedule Version 4, 2014* (Schedule) provides a management tool for identifying and determining the retention and disposal requirements for patient records created or received by WA Health. The Schedule contains valuable information and provides guidance to WA Health with respect to the major categories of patient records. It is therefore an important business tool and assists compliance with legal obligations.

This Schedule has been created to form part of the Recordkeeping Plan for WA Health as required under section 16(3)(a-c) of the [State Records Act 2000](#).

The aims of the Schedule are to:

- support efficiencies in the management of patient records, particularly with regard to retention and disposal
- prevent the premature destruction of records which need to be retained for a specific period to satisfy legal, financial and other requirements
- authorise the destruction of records not required for permanent retention
- identify records worth preserving permanently as State archives, which will be transferred to the State Records Office of Western Australia (SRO) for permanent storage.

1.3 Scope of the Patient Information Retention and Disposal Schedule

This Schedule provides retention and disposal guidance for patient records created or received by WA Health. These patient records may exist within (and be maintained by) a medical records

service, or within individual departments or clinical units of public health care facilities. The Schedule applies to patient records in all formats (refer to [Section 1, Part 3.1 – Formats](#)).

This Schedule supersedes the Operational Directive: *Patient Information Retention and Disposal Schedule Version 3, 2008 (OD 0133/08)*.

Records already sentenced under previously approved Schedules and that are still in the custody of WA Health will be re-sentenced as necessary in accordance with this Schedule.

This Schedule is applicable to all staff members (employees, contractors, students, volunteers and agency personnel) of the Department, Health Service Provider or a person engaged under a contract for service by the Minister, Department CEO or a Health Service Provider.

This Schedule does not apply to WA Health administrative records, non-patient functional records, financial and accounting records, or human resource management records.¹

1.4 Revision of the Patient Information Retention and Disposal Schedule

The Resourcing and Performance Division within the Department will review this Schedule at least every 5 years.

The revised Schedule will be submitted to the Chief Executive Officer (Director General) of the Department of Health and the State Records Commission of Western Australia (SRC) for approval prior to its implementation.

If any record categories, associated with patient medical records, are found, for example, arising from a new function or new record type, and are not referred to in this Schedule, they must not be destroyed. In such a situation the Department must be contacted with a request to amend the Schedule. No records in such a category are to be destroyed until an amended Schedule has been approved by the SRC. Any unauthorised destruction of records is an offence under section 78 of the State Records Act.

All enquiries and written submissions seeking amendments to the Schedule should be directed to:

Senior Policy Officer
Re: Patient Information Retention and Disposal Schedule Version 4, 2014
Performance Directorate
Resourcing and Performance Division
Department of Health, Western Australia
PO Box 8172
Perth Business Centre
PERTH WA 6849

Telephone: (08) 9222 2311

E-mail: RoyalSt.PSPInfoManagement@health.wa.gov.au

¹ For information about the retention and disposal of administrative, financial and accounting, and human resource management records, visit the [State Record Office of Western Australia Recordkeeping website](#).

2 Recordkeeping environment

2.1 Legislation

Relevant Western Australian legislation and regulations include, but are not limited to:

- *Births, Deaths and Marriages Registration Act 1998*
- *Children's and Community Services Act 2004*
- *Coroners Act 1996*
- *Drugs of Addiction Notification Regulations 1980*
- *Electronic Transactions Act 2011*
- *Evidence Act 1906, Acts Amendment (Evidence) Act 2000*
- *Freedom of Information Act 1992*
- *Health Act 1911*
- *Health (Cervical Cytology Register) Regulations 1991*
- *Health (Notification of Adverse Event after Immunisation) Regulations 1995*
- *Health (Notification of Lead Poisoning) Regulations 1985*
- *Health (Venereal Diseases) Regulations 1973*
- *Health (Western Australian Cancer Register) Regulations 2011*
- *Health Legislation Administration Act 1984*
- *Health Services Act 2016*
- *Human Tissue and Transplant Act 1982*
- *Limitation Act 2005*
- *Mental Health Act 1996* (replaced by *Mental health Act 2014*)
- *Mental Health Act 2014*
- *Mental Health Regulations 1997* (repealed)
- *Notification of Stillbirth and Neo-Natal Death Regulations 2003*
- *Poisons Act 1964*
- *Poisons Regulations 1965*
- *Public Sector Management Act 1994*
- *State Records Act 2000.*

2.2 General disposal authorities

The [General Disposal Authority for State Government Information GDA 2013-017](#) produced by the SRO must be used for WA Health's general administrative, financial and accounting records and human resource management records.

2.3 Freedom of information

The *Freedom of Information Act 1992* prescribes the rights and procedures for access to documents held by government organisations. If a request for access under the Freedom of Information Act has been lodged, all records relevant to the request must be identified and preserved until action on the request and on any subsequent reviews by the Information Commissioner or the relevant court are completed. This applies regardless of whether the records in question are due for destruction.

Freedom of Information requests that have been identified as State archives must contain copies of the records that were the subject of the requests.

2.4 Investigations and inquiries

If an investigation or inquiry is likely, imminent or in progress, all records relevant to the investigation or inquiry must be identified and preserved until the action and any subsequent actions are completed.

2.5 Cessation of authority

Should the Department or a Health Service Provider cease operation at some time in the future, responsibilities for the management of records and information requests must be assigned to another government agency. For the purposes of this Schedule, records that must be held for a statutory period which extends beyond the operation of the Department or Health Service Providers will be transferred to an appropriate agency at the time of cessation.

3 Western Australian health records

3.1 Formats

Patient records regardless of their format must be sentenced in accordance with the Schedule.

3.1.1 Born digital/electronic records

Born digital records and electronic records are considered synonymous in the Schedule and are defined as records that are solely created, captured, recorded, stored and conveyed on any digital storage medium, such as a computer, and only originate in a digital format (e.g. e-mail, database records, e-forms).

Born digital records are subject to the provisions of this Schedule in the same way as hard copy records. Born digital records must be maintained and preserved in accordance with [‘Section 1, Part 3.5 – Archives not transferred to the State Records Office of Western Australia’](#) and the [State Records Commission Standard 8 – Digital Recordkeeping](#) to ensure these records are accessible for as long as they are required under the Schedule. If these records are not preserved, there is a risk of losing data. Born digital records should be monitored to identify any formats that are at risk of obsolescence.

3.1.2 Digitised patient record

A digitised patient record (DPR) is a record that has been transformed into a digital format from scanning a paper-based patient record (i.e. source record). The source record is the systematic documentation of a single patient’s medical history and includes, but is not limited to, notes captured at examination, treatment plans, medication charts, correspondence between treating clinicians and diagnostic reports.² This information is documented, in the first instance, on paper and filed in the patient’s medical record. The DPR is the scanned equivalent of the source record.

² Refer to [Section 2](#) of the Schedule for a comprehensive list of source records eligible for digitisation.

DPRs are subject to the provisions of this Schedule in the same way as hard copy records and must be managed in accordance with the [Digitisation and Disposal of Patient Records Policy](#) (Digitisation Policy) and supporting [Digitisation Policy Toolkit](#) documentation (Toolkit).

The documents comprising the Toolkit include the following:

- 1) *Eligibility of Paper-Based (Source) Records for Early Disposal After Digitisation*
- 2) *Technical Standards for Digitisation*
- 3) *Security Protocols and Ongoing Management of Digitised Patient Records*
- 4) *Quality Assurance Guidance*
- 5) *Metadata Guidance.*

The Digitisation Policy and Toolkit are to be used in conjunction with the Schedule with respect to the digitisation of source records that are within the scope of the Schedule.

3.1.3 Microforms

Microform is a general term that describes the photographic film used to store reduced size images of textual or graphic material. Two types of microform are microfilm and microfiche. Microfilm stores images in a linear arrangement on long strips of photographic film that are mounted on reels, cartridges, or cassettes. Microfiche stores images in a grid arrangement on sheets of photographic film that are stored in jackets. Microfilming is a general term for the photographic process used to record textual or graphic material on microform.

WA Health has traditionally transferred patient records onto microform. A microform reader is used in projecting and viewing these patient records to readable proportions. Patient information stored as microform must be sentenced in accordance with the Schedule.

3.1.4 Audiovisual records

Audiovisual records (including photographs, videotapes, films and audiotapes) are to be sentenced in accordance with the subject matter to which they relate.

The content of photographs must be identifiable; that is, the individual, places, events and dates depicted in them must be identified. If the content is not identifiable, the Department will consult with the SRO for further advice regarding the image.

The sentencing of audiovisual records must be considered in relation to:

- their subject matter
- documentary material that relates to their creation and use.

A photograph, cassette tape or other audiovisual record should be viewed as part of a larger set of records; that is, those records that document why it was taken and how it was used. Disposition of audiovisual material must be consistent with these records.

3.1.5 Samples and specimens

Retention and disposal guidance for biological samples, specimens and reports is included in the Schedule (Refer to '[Section 2, Part 11 – Pathology, laboratory records and diagnostic material](#)'). The minimum retention periods are based on the *National Pathology Accreditation Advisory Council's Requirements for the Retention of Laboratory Records and Diagnostic Material*. These guidelines should also be consulted for further details or clarification and may be found on the Australian Government Department of Health website: <http://www.health.gov.au/npaac>

Biological samples and specimens must be identifiable and held in appropriate storage conditions. The sentencing of samples and specimens must be considered in relation to the:

- sample or specimen type
- type of laboratory processing
- reason for collection of the sample or specimen
- significance of test results.

3.2 State archives

Records that have a disposal action of 'archive' within the Schedule are deemed or appraised as having continuing value and therefore must be retained permanently. Under the terms of the State Records Act, State archives that are in paper (hard copy) format are to be transferred to the SRO for ongoing preservation and future access, once reference at a facility level is no longer required.

Section 32 of the State Records Act provides that State archives older than 25 years will be transferred to the custody of the SRO. The Schedule sets out the period of time for which State archives may be held in the custody of health care facilities. Facilities that wish to undertake responsibility for managing their own State archives, or otherwise need to retain them for longer than the 25 year period, must submit an application to gain approval from the SRC.

3.3 Temporary record

Temporary records refer to records that may be destroyed once the minimum period for which the records must be retained has expired and the records are not required for any further legal or business purpose. A temporary record can exist in any format. Once a temporary record has reached the minimum period of retention it can be authorised for destruction in accordance with the Schedule.

3.4 Restricted access archives

A restricted access archive is 'a 'State archive' that is a government record and to which access is restricted until it is of a certain age' (State Records Act, pt 1, s 3). Part 6 of the State Records Act provides for the restriction of certain categories of State archives.

Patient information contained within State archives (permanent value records) is accessible to the public after a 100 year restricted access period that applies from the date of last access of the record. Restricted access archives are identified within this Schedule and until the restricted access period for these records expires, access may be granted by the facility which created the records, regardless of whether the record is in the custody of the facility or the SRO. Access to

these archives is subject to confidentiality of the records not being breached and in accordance with privacy requirements.

The 100-year restricted access period has been applied to ensure that access to sensitive information does not occur while the individual to whom it refers is still alive. However, such restrictions need not preclude access for reasonable bona fide research purposes. Researchers may apply to a public health care facility, or via the SRO, for access to records before the 100 year restriction has expired.

The 100-year period will commence from the date the record was last accessed, and not the date that the record is transferred to the SRO. The 100-year period will apply to records created on or after 1 January 1920. Records created prior to 1 January 1920 will remain open to access.

After 100-years, State archives will be open to the public. Where a public health care facility is no longer operating, and the records are not in the custody of the SRO, the Department will manage requests for access to restricted access records.

3.5 Archives not transferred to the State Records Office of Western Australia

Section 32 of the State Records Act provides that State archives older than 25 years will be transferred to the custody of the SRO. The Schedule sets out the period of time for which State archives may be held in the custody of health care facilities.

WA Health intends to transfer all State archives to the SRO, except those State archives that need to be held in electronic form. For example, digitised records and the electronic patient master indexes held in patient administration systems must be maintained and preserved by WA Health (unless they can be suitably printed into hard copy form). The patient administration systems that are currently operational within WA Health include: Health Care and Related Information Systems (HCARe), The Open Patient Administration System (TOPAS) and Web Patient Administration System (webPAS).

WA Health intends to maintain and preserve all records that have been digitised or are born digital. This includes ensuring all records are accessible for as long as they are required under the Schedule, as well as ensuring that digital and born digital records are migrated and preserved across systems to retain the integrity and authenticity of the records. It is therefore important to ensure that hardware/software required to interpret electronic health information is accessible for the life of the information.

Policy frameworks relating to the management and long term preservation of patient information that should be considered in conjunction with the Schedule include:

- *Information Management Policy Framework*
- *ICT Policy Framework.*

3.6 Retention of records relating to Aboriginal people

3.6.1 State Records Act, Section 76

The State Records Act is the principal statute that governs the keeping of records in Western Australia, including the retention of records relating to Aboriginal people.³ Section 76 of the State Records Act relates to determining the significance of State records from an Aboriginal cultural and heritage perspective. Section 76 should be considered in association with the requirements of the Schedule relating to the retention of Aboriginal patient records.

3.6.2 Western Australian Health

To preserve records relating to Aboriginal people, health care facilities and agencies must retain Aboriginal patient records indefinitely⁴ for clients with a date of birth prior to and including 1970. This excludes Case Management Program records, which given their complex nature and sensitivity may be destroyed upon fulfilment of specific minimum retention periods (refer to [‘Section 1, Part 3.9 – Case Management Program records’](#)).

In addition to this, Aboriginal patient records created by remote clinics in the Kimberley and Pilbara health regions must also be kept indefinitely, with the exception of Case Management Program records.

Refer to [Appendix 1](#) for a map of health districts in WA, including remote areas of WA.

To identify and subsequently preserve records of Aboriginal people, facilities are advised to consider the following:

- the Aboriginal status recorded on health information systems (e.g. HCARE, TOPAS, webPAS and local administrative systems)
- the record is of an individual with a recognised Aboriginal family name, including aliases
- the record relates to an individual of an identified Aboriginal community (e.g. clinic records)
- the record relates to care delivered by a health service, including Mission, Station and itinerant health workers
- the record relates to a health program that provided care to the Aboriginal population (e.g. eye health)
- the record exists in an area with a high proportion of Aboriginal population, such as the Kimberley region
- the record contains evidence of adoption, fostering or an informal arrangement of care for a child.

Refer to [Appendix 2](#) for a decision flow diagram for the retention of patient records relating to Aboriginal people.

³ Within Western Australia, the term Aboriginal is used in preference to Aboriginal and Torres Strait Islander, in recognition that Aboriginal people are the original inhabitants of Western Australia. No disrespect is intended to our Torres Strait Islander colleagues and community.

⁴ A digitised version of the patient record may be created with the intention that the digitised version will stand in place of the source record as the official record of business. Refer to [‘Section 1, Part 3.10.1 – Digitisation’](#) for conditions relating to the digitisation of source records.

Health care facilities are requested to contact the following officers for further information:

- Senior Policy Officer Tel: (08) 9222 2311 (patient records)
- Document Control Officer Tel: (08) 9222 4347 (administrative records)
- Manager Statewide Policy and Strategy Tel: (08) 9222 4412 (Aboriginal health enquiries)

3.7 Psychiatric patient records

All psychiatric patient records are to be retained for 7 years following death.

It is important that a psychiatric patient record is maintained for the lifetime of such individuals, for the purpose of ongoing treatment and/or in the event that mental competency is regained.

Although there is no clear definition, information requirements outlined in the *Mental Health Act 1996*, the [National Health Data Dictionary](#) and the [Mental Health National Outcomes and Casemix Collection: Technical Specifications of State and Territory Reporting Requirements](#) indicate that a psychiatric patient record is any record of a patient admitted for a psychiatric episode or episodes of care to a mental health care facility.

A mental health care facility includes the following:

- public hospitals, or part of a public hospital, that is authorised under section 21 of the Mental Health Act
- public community residential mental health facilities
- public community based mental health facilities (providing ambulatory mental health services).

Where health care facilities maintain an integrated patient record, in which psychiatric notes are included, professional judgement should be exercised in determining whether such records should be considered 'psychiatric' in accordance with the above interpretation.

Refer to [Appendix 2](#) for a decision flow diagram on the retention of psychiatric patient records.

3.8 Obstetric records

All obstetric records which contain information relating to a newborn may be destroyed 15 years after the date of last attendance of the newborn/patient or after the date of last access, provided the patient has attained the age of 25 years. However, where information relating to an uncomplicated newborn delivery is recorded in the mother's record, the record may be destroyed as per the mother's record; that is, 15 years after the mother's last attendance or after the date of last access (provided the mother has attained the age of 25 years).

Where information relating to a newborn is documented in the mother's record and there is evidence of obstetric complication, the record should be destroyed 15 years after the date of last attendance of the newborn/patient or after the date of last access (provided the newborn has attained the age of 25 years).

Refer to [Appendix 2](#) for a decision flow diagram on the retention of obstetric (and newborn) patient records.

3.9 Case Management Program records

Case Management Program (CMP) records include case notes and reports created and maintained by the Department Case Management Unit. Due to their complex nature and sensitivity, CMP records may be destroyed upon fulfilment of specified minimum retention periods, regardless of Aboriginal status.

3.10 Reproduction of records

The SRO [General Disposal Authority for Source Records RD 2009027](#) refers to the amendments to legislation that have enabled the use of an accurate reproduction of documentation as admissible evidence in the courts. Section 73A (1) of the Evidence Act states:

‘A document that accurately reproduces the contents of another document is admissible in evidence before a court in the same circumstances, and for the same purposes, as that other document, whether or not that other document exists.’

It is WA Health’s responsibility in terms of its risk management analysis to decide whether to create, retain and rely on a reproduction, in whatever format, of an original record.

3.10.1 Digitisation

Digitisation is the process of converting paper-based records (i.e. source records) to digital format. Whether a DPR can stand in place of the source record as proof of patient care, or as evidence, depends on its authenticity, completeness, reliability and usability. Health Service Providers must refer to the Digitisation Policy and Toolkit within the Information Management Policy Framework to determine whether source records can be destroyed after digitisation.

The Digitisation Policy and Toolkit provides WA Health with comprehensive guidance on digitising source records and covers the disposal of source records after digitisation. The Digitisation Policy outlines eight principles relating to the digitisation and disposal of source records and the ongoing management of the digitised copy. The Toolkit provides further guidance on meeting the requirements of the Digitisation Policy. The Digitisation Policy and Toolkit ensures that best practice recordkeeping tools and processes are in place prior to the disposal of source records and aligns with the requirements of the SRO [General Disposal Authority for Source Records RD 2009027](#).

The digitisation and subsequent disposal of source records may only occur if the Digitisation Policy and Toolkit have been strictly adhered to and the conditions outlined in the Schedule are met (refer to [‘Section 1, Part 4.4.2 – Disposal of source records after digitisation’](#)).

4 Western Australian Health recordkeeping practices

4.1 Date of last access

The retention period for most records is calculated or determined from the 'date of last access'. The date of last access refers to the last time the record was accessed for purposes directly related to the care of the patient. This includes accessing the record for:

- a patient admission, including the delivery of acute or post-acute care in the patient's home as a substitute for being in hospital (i.e. Hospital in the Home)
- a non-admitted patient service, including emergency, outpatient, community health or community-based treatment programs.

The date of last access is not affected where the record is accessed for purposes not directly related to the care of the patient. Some examples of purposes not directly related to the care of the patient are:

- records accessed for education of health professionals
- records accessed for research
- records accessed for the provision of a report to another health care worker or agency
- records accessed for the patient's or deceased's next of kin
- records retrieved for a Freedom of Information application, a subpoena or other medico-legal request
- records retrieved for post-discharge completion
- records retrieved for general processing (e.g. filing of documentation)
- records retrieved for clinical review
- records retrieved for the provision of copies of patient record documentation.

It is recommended that health care facilities exercise professional judgement in determining the date of last access. Consideration must be given to the reason for access and whether the purpose was directly related to patient care.

The date of last access is commonly flagged on the cover of a patient record by an (appropriately placed) retention label that indicates the year the patient record was last accessed.

4.1.1 Application

The patient to which the records relate must attain the minimum age requirement (e.g. 25 years) before the assigned retention period is applied. For example, the minimum retention period for an inpatient neonatal record will be 40 years (25 + 15 years). The record must be retained until the child would have attained 25 years of age. The record must be retained for a further 15 years from date of last access in accordance with the Schedule.

Records of deceased patients must have the assigned retention period from the date of last access added to the date of death or minimum age requirement, whichever is the longer. For example, the minimum retention period for a child that dies at the age of 15 will be 20 years (10 + 10 years). The record must be retained for 10 years until the child would have attained 25 years of age. The record must be retained for a further 10 years from date of last access in accordance with the Schedule.

Refer to [Appendix 2](#) for decision flow aids to assist with determining the retention period of specific records.

4.2 Sentencing

Determining the appropriate minimum retention period of a patient record is a process that needs to commence at record creation. It is beneficial to adopt a concurrent (rather than retrospective) record sentencing process.

While minimum retention requirements are absolute, there is nothing to prevent a facility from retaining records of temporary value for periods well beyond the specified minimum retention period. This may be considered appropriate at a local level for ongoing access or future research (refer to '[Section 1, Part 4.5 – Significance of records](#)').

Where it is known or there is a reasonable expectation that a record or series of records may later be subject to legal proceedings, health care facilities are to retain these records for future reference. Records that are currently the subject of legal proceedings must be retained until the action and any subsequent actions are completed (for retention and disposal guidance refer to [Section 2, Index No. 4.1](#)).

A system which indicates the year in which the record was last accessed is useful for the record sentencing and management process. A coloured year retention label may appear on the record cover to indicate the year of the date of last access.

Notations to this effect in an index or register may also be useful. When the time comes to cull inactive records for disposal, records accessed up until a particular year can be readily identified. Health care facilities may also use similar systems to identify State archives and deceased patient records.

Where possible, in order to facilitate timely disposal of records, health care facilities should configure their electronic recordkeeping systems to sentence electronic records and DPRs at the time of creation or capture. It is recommended that measures be in place for these types of records to confirm the minimum retention period has been satisfied in accordance with the Schedule.

4.3 Storage

Facilities that are unable to store patient records of temporary value on site due to space restrictions, may wish to engage the services of a commercial record management company.

The following documents will be of assistance where the option of off-site storage is pursued:

- [State Records Commission Standard 6: Outsourcing](#)
- *Department of Finance – Storage, Retrieval and Destruction Services for Paper and Electronic Records*. This document is available on the [Department of Finance Whole of Government Contracts WA](#) website.

4.4 Disposal of State records

4.4.1 Responsibility for disposal of State records

Before any patient records are destroyed or transferred to the SRO, they must be reviewed and authorised for destruction or transfer by the Data Custodian. For further information about the role and responsibility of the Data Custodian refer to the *Data Stewardship and Custodianship Policy*.

4.4.2 Disposal of source records after digitisation

The destruction of source records 6 months after successful digitisation is permitted provided certain conditions are met and the minimum requirements of the Digitisation Policy and Toolkit are satisfied. The conditions for the disposal of source records within the Digitisation Policy aligns with the SRO [General Disposal Authority for Source Records RD 2009027](#), which is the continuing authority for the destruction of source records that have been successfully digitised.

The disposal of source records **is PERMITTED ONLY IF ALL these conditions are met:**

- WA Health's digitisation program meets the minimum compliance requirements of the [State Records Commission Standard 8 Digital Recordkeeping: Principle 6 – Digitization](#). The Digitisation Policy and Toolkit documents address these requirements.
- The process used to create the DPR meets or exceeds the Digitisation Specification outlined in the Digitisation Policy and the Toolkit document *Technical Standards for Digitisation*.
- The DPR is registered or captured in an Electronic Document and Records Management System or business information system with recordkeeping capabilities at the time of digitisation.
- WA Health's records are digitised within 5 years of their creation, ensuring that they are physically capable of reproduction and that the digitisation process is part of the normal, current business practice.
- The DPR has the required degree of authenticity, integrity, reliability and usability necessary to substitute for the source records for the purposes for which the source records were created or kept.
- The DPR will be kept and be accessible for as long as required under this Schedule.
- The source records are covered by this Schedule.
- The source records are kept for an appropriate length of time after digitising for quality control purposes.

The minimum period a source record must be retained is 6 months following successful digitisation.

Disposal of source records **is NOT PERMITTED if any of these conditions applies:**

- Source records are digitised more than 5 years after the records were created, such as in a retrospective or back-scanning records project.
- The source records have significant aesthetic or format-based value (e.g. original proclamations, charters, testimonials, intergovernmental treaties or artwork).
- The source records contain a physical element attesting to their authenticity or evidential value (e.g. a corporate seal or watermark).
- The source records are subject to a written law, or a government policy or directive that requires the source records to be kept in original format.
- The source records are not covered by this Schedule.

4.4.3 Disposal of duplicates or copies of State records

Duplicates or copies of records are defined as exact copies of original records; that is, where no annotations or signatures have been added and where the original record forms part of the WA Health recordkeeping system. If the original copy has been annotated or signed then the modified version is not considered an exact replica of the original and will need to be retained within the recordkeeping system. Duplicates or copies of records may be destroyed once the originals have been captured by the recordkeeping system and they are no longer needed for reference purposes.

4.5 Significance of records

It is important that some discretion be applied to the decision to destroy records with potential business or historical value. Some records may appear to have no long-term value at the time a particular sentence was developed or applied. However, the value of these records may change by the time the minimum sentences have expired. The passing of time helps the re-evaluation process. Those responsible for managing patient records should be alert to factors which may influence the business or historical value of records.

This part is intended to apply to acute hospital patient records (refer to [Section 2, Index No. 1.1 – 1.3](#)); however, health care facilities may apply this guidance to any other class of record that may be destroyed (i.e. of temporary value). As a (non-exhaustive) guide, the following factors may be considered during the re-evaluation process. An individual patient record may be considered to be of business or historical value where it:

- relates to genetic information that offers insight into the potential for acquiring a condition, or serves as an explanation for a disease (including the likelihood that offspring will inherit a related trait or condition)
- concerns diagnoses that are controversial, new or rare
- concerns treatment or diagnostic interventions that are considered innovative or controversial
- concerns diagnoses and/or treatment that are attracting class action litigation
- relates to controversial matters
- relates to major obligations or liabilities of health care facilities and/or the State
- relates to matters that are attracting community-wide interest
- otherwise (significantly) impacts or affects the health care facility's functions or operations.

Individual patient records that are selected, based on the factors outlined above, are considered to have been sampled. Once records have been sampled they are considered to be State archives, and must be retained permanently. Sampled records are to be transferred to the SRO. Refer to [Section 2, Index No. 1.6](#) for further retention and disposal guidance on sampled individual patient records.

Specific advice on assessing the historical or other significance of records may be sought from the State Records Office particularly where the records are being considered for destruction. Telephone: (08) 9427 3600.

4.6 Recommended methods of disposal

Records authorised for disposal within the Schedule (i.e. those records that have a disposal action of 'Destroy') may be destroyed after the specified minimum retention period has elapsed.

In accordance with the *Information Storage and Disposal Policy*, the disposal of patient records must be secure and confidential. WA Health may make arrangements for records to be destroyed by an external contractor. Where disposal is undertaken by external contractors, a certificate confirming the secure, confidential and complete disposal of the records must be provided by the external contractor. Secure transport and storage pending disposal of the records is required.

Information on Common Use Agreements for Records Management functions such as the storage, retrieval and destruction of paper and electronic records is available on the Department of Finance Whole of Government Contracts WA website at:

<http://www.contractswa.finance.wa.gov.au/index.jsp>

4.6.1 Methods of disposal for paper records

Shredding is a means of destroying paper records by mechanical cutting into a multitude of narrow strips (strip-shred) or particles (cross-shred). For shredding to be effective in the destruction of patient records, it must render all information incapable of reconstruction.

Pulping is the process whereby paper records are prepared for recycling by chemical and/or mechanical methods.

Incineration (or burning) is not recommended as a reliable and environmentally sound means of record destruction.

Patient records must never be buried or disposed of within conventional rubbish repositories or council tips. Where the destruction of paper records is outsourced to a third party, such as a contractor, the health services remain responsible for ensuring that the contractor meets the minimum requirements of this Schedule. This applies to the destruction of source records that are disposed of at least 6 months after successful digitisation. Refer to the Toolkit document *Eligibility of Paper-Based (Source) Records for Early Disposal After Digitisation* for further information about the destruction of source records following digitisation.

4.6.2 Methods of destruction for digital storage media

WA Health must not dispose of digital storage media that store patient records without using appropriate data sanitisation and/or physical destruction methods prior to disposal. All digital storage media containing patient records must be sanitised prior to reuse in a new environment, or where the media is to be used for storage of a different type of information.

Sanitisation involves erasing or overwriting data stored on digital storage media. This process results in the loss or destruction of records, however, it does not involve the physical destruction of the media.

Destruction or disposal involves physically damaging the digital storage media with the objective of making the data stored on it inaccessible.

Patient records stored on digital storage media must be destroyed in a manner that ensures that data is not recoverable electronically. In general, there is no known method short of total destruction which will completely remove all traces of the information held by digital storage media. However, some sanitisation measures can significantly reduce the risk of information being recovered from used media.

Sanitisation and destruction measures may be used separately or in combination. Selection of appropriate sanitisation and destruction measures is dependent upon the storage media type, ability to apply sanitisation, sensitivity of the data stored and a risk assessment. Selection of appropriate sanitisation or destruction measures is the responsibility of WA Health. WA Health must ensure digital storage media have been sufficiently sanitised and/or destroyed prior to re-use or disposal of the media.

Deleting records from digital storage media such as rewritable optical disks, USB storage devices and hard disks does not result in confidential destruction as the data can be recovered. Commercial tools are available to scan storage media and identify recoverable files in such circumstances. Alternate methods of data sanitisation or physical destruction need to be used for digital storage media.

Sanitisation and destruction of digital storage media needs to be undertaken in accordance with applicable occupational safety and health requirements. Health Support Services should be consulted for guidance on destruction of data stored on digital storage media.

Reformatting, also known as reinitialising, results in the loss of previously stored data on the media. Reformatting is a basic form of sanitisation and can only be used when the media will continue to store patient record (confidential) information and remain in its existing environment. The original contents of the media must be 'deleted' prior to the media being reformatted. Limited types of digital storage media may be reformatted.

Magnetic media overwrite or file shredding software enables digital storage media to be overwritten many times with random characters. This process is a form of sanitisation and renders the underlying, previously stored data beyond easy recovery. The media may be subsequently reused for other purposes.

The standard method used for overwriting is to write over every addressable location with one pattern (usually binary 'ones') and then with the complementary pattern (binary 'zeros'). This cycle of overwrites is then repeated a number of times, where the number is based on the sensitivity of the data stored, and whether the media will be subsequently reused or destroyed. Commercial products are available to perform overwriting or file shredding on digital storage media.

Degaussing is a procedure that reduces the magnetic flux density to zero by applying a reverse magnetising field to the digital storage media. Degaussing renders any previously stored data on the storage media unreadable. Commercial products are available to perform degaussing of digital storage media.

4.6.3 Methods of disposal for non-electronic and non-paper records

Videos, cinematographic film and microforms (including microfilm, microfiche and x-rays) can be destroyed by shredding, cutting, crushing or chemical recycling. It is recommended microforms are destroyed confidentially by shredding.

4.7 Destruction register for all record formats

A register of records destroyed must be maintained for future reference and accountability. The destruction register needs to be consistently and accurately maintained whenever patient records are destroyed. It is strongly recommended that the destruction register captures details of each individual record that is destroyed, rather than a description of a group or series of records, and make reference to the relevant Retention and Disposal Authority.

The register should also contain some detail of the date range of the records destroyed. Where an external contractor is used to provide record destruction services, reference must be made to the name of the company and the location of the service.

A destruction register needs to record the following information as a minimum.⁵

Information Type	Description
Disposal authority number	Indicates the retention and disposal schedule that authorises the destruction of records. For example, RD 2007079.
Index number	Refers to the type or class of record.
Description	Provides a description of the individual record item being destroyed. For individual patient records, the Unique Medical Record Number (UMRN), patient surname and given names may be collected.
Date range	Indicates the inclusive dates of records being destroyed (e.g. 1950 – 1955).
Date of destruction	Refers to the date records are destroyed.
Company	Refers to the name of the contractor providing destruction services, and the location of the service (if applicable).
Method of destruction	Specifies how the records are destroyed. For example, shredding.
Certification	Indicates that records have been destroyed in accordance with methods outlined in WA Health's approved retention and disposal schedule. An officer delegated the authority to destroy records, or who witnesses the destruction of records by a contractor, may sign this part of the register as certification or cross-reference to other certification documentation.

[Appendix 3](#) provides a sample record destruction register.

⁵ Refer to the Toolkit document *Metadata Guidance* for further information about metadata requirements pertaining to the destruction of source records following successful digitisation.

5 Arrangement and definitions of terms used in the Patient Information Retention and Disposal Schedule

5.1 Arrangement

The Schedule is divided into three sections.

[Section 1](#) provides an introduction to this document, and information on WA Health's recordkeeping environment, types of records, and recordkeeping practices.

[Section 2](#) contains the Schedule notes. The following details of each identified class of record are provided:

- index number
- description of the class of record
- disposal action (destroy or archive)
- sentence (or minimum retention period)
- custody arrangements
- review status.

[Section 3](#) contains the appendices. The appendices provide supplementary information to support [Section 1 – Introduction](#).

5.2 Definitions

Accessible - able to read or interpret as having meaning.

Age Minimum – is the minimum age at which the record can be sentenced.

Agency - any facility, health related or otherwise, that stores and maintains records.

Archival value - means continuing or permanent value warranting preservation.

Archive - a record category identified as having continuing value, that is to be transferred to the SRO for permanent retention as a 'State archive'.

Archive within agency - a record category identified as having archival value and which is held in electronic form. In the case of the Department ceasing to exist and no successor agency being identified, the SRO will be consulted.

Assigned Retention Period – is the amount of years a record is required to be kept before they are able to be destroyed.

Authentic - means the digitised version replicates the attributes of the source record and can be proven to be what it purports to be.

Born digital record – refer to 'Electronic record'.

Business information system - is an automated system that creates or manages data about an organisation's activities.

Case Management Program record - temporary value record containing sensitive and confidential information on individuals who knowingly expose other persons to the risk of human immunodeficiency virus (HIV) infection. Other information contained in this type of record may include status and history of sexually transmitted diseases, substance abuse, mental health problems, sexuality, names of sexual and/or drug use partners as well as case notes and correspondence.

Contracted Health Entity - means a non-government entity that provides health services under a contract or other agreement entered into with the Department CEO (Director General) on behalf of the State, a Health Service Provider or the Minister.

Class of record - describes the type of record, its contents and the medium on which data is recorded and stored.

Client - refer to 'Patient record'.

Client record - refer to 'Patient record'.

Completeness - means the digitised version has all the necessary or component parts of the source record.

Custody - where the record needs to be held pending its destruction (records of temporary value), or when archived (records of permanent value).

Data Custodian - has responsibility for the ongoing development, data collection, maintenance and review of the collection. The Data Custodian is responsible for the quality of the data, its security, timeliness and adherence to standards.

Date of last access - refers to the last time the record was accessed for purposes directly related to the care of the patient. This includes accessing the record for:

- a patient admission, including Hospital in the Home
- a non-admitted patient service, including emergency, outpatient, community health or community-based treatment programs.

The date of last access is not affected where the record is accessed for purposes not directly related to the care of the patient.

Department CEO means the Chief Executive Officer (Director General) of the Department of Health.

Destroy - a record category identified as having temporary value, and which ultimately will be destroyed.

Destroy when reference ceases - indicates that a patient record may be destroyed once 'reference' is no longer necessary. This is an instruction which may be applied at the health care facility's discretion – only within the limits of the Schedule. For example, if a facility no longer has

an identified need to access a particular set of State records, they may be destroyed at the facility's discretion.

Digitisation - refers to the creation of digital images from paper documents by such means as scanning.

Digitised records - include health records produced by digitisation. Digitised health record and scanned health record are synonymous in this document.

Disposal action - the final disposition will be either Archive, Destroy, or Archive within Agency.

Electronic Document Records and Management System - means an automated system used to manage the creation, use, management and disposal of physical and electronically created documents and records for the purposes of:

- supporting the creation, revision and management of records
- managing retention and disposal of records
- improving an organisations workflow
- providing evidence of business activities.

Electronic record - refers to data created, captured, recorded, stored and conveyed on any digital storage medium, such as a computer, and only originate in digital format (e.g. e-mail, database records, e-forms).

Health care facility - an organisation that is directly responsible for the delivery of health services to patients.

Health Service Provider means a health service provider established by an order made under section 32 (1) (b) of the *Health Services Act 2016*.

Health Support Services - is a Chief Executive – governed health service provider that is a statutory authority accountable for the delivery of support services including, but not limited to, the delivery of technology, supply, workforce and finance services across WA Health.

Imaging records - refers to diagnostic radiology, nuclear medicine, ultrasound, computed tomography, magnetic resonance imaging, photographs, videotapes, films and audiotapes.

Index No. - the reference number assigned to each individual record or class of records.

Individual - a natural person.

Integrity - means the digitised version has the same degree of completeness as the source record, so that it is able to be used for the same purposes as the source record.

Master copy - a faithful reproduction of an original record optimised for authenticity, reliability, integrity and availability. Masters are captured at the highest practicable quality or resolution and stored for long-term use. Master copies are not capable of being modified and edited. Master copies are generally produced where the intention is to subsequently destroy the original paper record (at a later time).

Metadata - data describing the context, content and structure of records. This must be captured to enable the record to be understood and to support its management and use through time.

Migration - is a preservation activity that transfers records from one hardware or software configuration to another or from one generation of technology to another.

Obstetric complication - any complication arising during the antenatal, delivery or puerperal periods.

Original record - a record that precedes all others in time and is not derived, copied or translated from another record. Original records may be paper-based or electronic.

Patient (Client)⁶ - means a person who has been, is being, or will or may be provided with health treatment or care.

Patient record - a documented account, whether in hard copy or either digitised or electronic form, of a client's/patient's health, illness and treatment during each visit or stay at a health service.

Policy framework - means a policy framework issued under section 26 of the *Health Services Act 2016*.

Psychiatric record - any record of a patient admitted for a psychiatric episode or episodes of care to a mental health care facility. A mental health care facility includes the following:

- public hospitals, or part of a public hospital, that is authorised under section 21 of the *Mental Health Act 1996*
- public community residential mental health facilities
- public community-based mental health facilities (providing ambulatory mental health services).

Recordkeeping plan - a document or series of documents that outlines the policies, practices and processes for the creation, storage, maintenance, retention and disposal of an organisation's records. A recordkeeping plan must be approved by the State Records Commission for the purposes of the *State Records Act 2000*.

Reference - indicates that the record has been used or accessed for any reason.

Reliable - means the contents of the digitised version can be trusted to be a full and accurate representation of the contents of the source record.

Reproduction - a copy or representation of an original record.

Restricted access - refers to State archives in which access is restricted until they are of a certain age. All records identified in this Schedule as being State archives are 'restricted access' archives.

Review status - indicates whether the details for a class of record are new, updated or remain unchanged from the previous version of the Schedule.

⁶ Patient and client are used interchangeably as appropriate throughout this Schedule.

Source record – in this context means a paper-based patient record where a digitised version has been created. The source record is the systematic documentation of a single patient's medical history and includes, but is not limited to, notes captured at examination, treatment plans, medication charts, correspondence between treating clinicians and diagnostic reports. This information is documented, in the first instance, on paper and filed in the patient's medical record.

Staff member - an employee of the Department or a Health Service Provider or a person engaged under a contract for service by the Minister, Department CEO, or a Health Service Provider.

State record - a government record.

Temporary record - means a record that may be disposed of once the minimum retention period has expired and the records are not required for any legal or business purpose.

Usability - the digitised version of the source record can be located, retrieved, presented and interpreted, and maintains the contextual links in the source record to the records and activities for which the source record was created.

WA Health - synonymous with WA Health System, means the Department of Health, Health Service Providers (North, South, WA Country, Child and Adolescent, and East Metropolitan Health Services, as well as the Quadriplegic Centre and Hospital Support Services), and contracted health entities.

Section 2 Schedule notes

1 Individual patient records – acute hospitals

The date of last access refers to the last time the record was accessed for purposes directly related to the care of the patient. This includes accessing the record for admitted and non-admitted patient services. It is recommended that health care facilities exercise professional judgement in determining the date of last access. Consideration must be given to the reason for access and whether the purpose was directly related to patient care.

Acute Hospital Patient Records - Documents relating to individual inpatients, outpatients and emergency patients in acute hospitals. This may include the documents below as a (non-exhaustive) guide:

<ul style="list-style-type: none">• Admission form• Allied health forms and reports• Antenatal or prenatal treatment• Authority for removal of tissue after death for transplant or anatomical purposes and for post-mortems• Autopsy or post-mortem (report)• Accident and emergency treatment• Certification by medical practitioner that consent is informed• Consent or authorisation for treatment, donation of tissue, photographs, release of information, special studies (e.g. clinical trials), special procedures (e.g. termination of pregnancy, sterilisation)• Consultation (report)• Correspondence: includes referral information. Excludes documents relating to legal claim• Dental models (refers to models created as a record of a patient's clinical condition at a particular point in time)• Discharge: includes final diagnosis, operative procedures, summary or letter, discharge at own risk or against medical advice• Doctor's or physician's orders• Epidural forms• Examination or physical examination• History: medical and social history of patient/family• Investigation reports: includes graphs, flow sheets, laboratory and diagnostic reports, electrocardiogram (ECG), electroencephalogram (EEG), electromyogram (EMG), cardiotocogram (CTG), monitor strips and fluid balance summary	<ul style="list-style-type: none">• Medication or drug orders and administration of medication or drugs (includes oral and parenteral)• Nursing care (except nursing care plans where revisions obliterate previous entries – see Index No.10.2 Nursing Care Plans)• Observations: includes vital signs, intensive care, head injury• Obstetric (mother's record): also refer to 'Section 1, Part 3.8' for requirements relating to obstetric records• Prenatal or newborn (record)• Perinatal morbidity statistics (record)• Photographs• Pre-registration form• Problem list or master problem list• Progress notes (includes those recorded on separate sheets by the various health professionals or together on one sheet)• Progress of labour• Refusal of treatment• Resuscitation records• Short-stay treatment• Surgical procedure or operation: includes pre-operative check lists, anaesthetic records, instruments, swab count records, post-operative observations• Therapeutic treatment: includes anti-coagulant, diabetic, dialysis, electric shock therapy (EST) or electroconvulsive therapy (ECT)• Therapeutic procedure• Transfer of patient
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* **Important:** An exception applies to Aboriginal patient records (refer to Section 1, [Parts 3.6](#) and [3.9](#)).

Index No.	Class of Record	Disposal Action	Sentence*	Custody	Review Status
1.1	<p>Records of Discharged Patients and Outpatients</p> <p>Refers to patient records, including records held by individual departments retained separately from the main hospital record (e.g. Departmental records).</p> <p>Notes</p> <ol style="list-style-type: none"> 1. Refer to Section 1, Part 3.8 for requirements relating to obstetric records. 2. Excludes psychiatric records – these must be retained for 7 years after the patient’s death (refer to Section 1, Part 3.7). 3. Individual patient records must be sampled. For further information on determining the significance of individual patient records refer Section 1, Part 4.5. Refer to Index No. 1.6 for retention and disposal requirements for sampled records. 	Destroy	Destroy 15 years after last attendance or date of last access (provided the patient has attained the age of 25 years)	Hold in agency pending destruction	Unchanged

* **Important:** An exception applies to Aboriginal patient records (refer to Section 1, [Parts 3.6](#) and [3.9](#)).

Index No.	Class of Record	Disposal Action	Sentence*	Custody	Review Status
1.2	<p>Records of Deceased Patients</p> <p>Refers to records of patients that have died while in hospital, or who are known to be deceased. This includes records held by individual departments retained separately from the main hospital record (e.g. Departmental records).</p> <p>Notes</p> <ol style="list-style-type: none"> 1. Refer to Section 1, Part 3.8 for requirements relating to obstetric records. 2. Excludes psychiatric records – these must be retained for 7 years after the patient's death (refer to Section 1, Part 3.7). 3. Individual patient records must be sampled. For further information on determining the significance of individual patient records refer Section 1, Part 4.5. Refer to Index No. 1.6 for retention and disposal requirements for sampled records. 	Destroy	Destroy 10 years after date of death or date of last access (provided the patient has attained the age of 25 years)	Hold in agency pending destruction	Unchanged
1.3	<p>Emergency Department Records</p> <p>Includes outpatient records of any public hospital that does not have a formally constituted outpatient department and that files its outpatient notes separately from the records identified in Index No. 1.1 – 1.2. Includes triage records, nursing post records, and documentation concerning patients who were dead on arrival.</p>	Destroy	Destroy 15 years after last attendance or date of last access (provided the patient has attained the age of 25 years)	Hold in agency pending destruction	Unchanged

* **Important:** An exception applies to Aboriginal patient records (refer to Section 1, [Parts 3.6](#) and [3.9](#)).

Index No.	Class of Record	Disposal Action	Sentence*	Custody	Review Status
	<p>Emergency Department Records continued</p> <p>Information includes the date and time of arrival, description of significant clinical, laboratory and radiological findings, details of treatment, time of discharge and attending medical officer.</p> <p>Where Emergency records are filed within records identified in Index No. 1.1 – 1.2, sentence according to these record classes.</p> <p>Notes</p> <ol style="list-style-type: none"> 1. Refer to Section 1, Part 3.8 for requirements relating to obstetric records. 2. Excludes psychiatric records – these must be retained for 7 years after the patient’s death (refer Section 1, Part 3.7). 3. Individual patient records must be sampled. For further information on determining the significance of individual patient records refer Section 1, Part 4.5. Refer to Index No. 1.6 for retention and disposal requirements for sampled records. 				
1.4	<p>Acute Patient Records: Duplicates</p> <p>Refers to paper duplicates of records identified in Index No. 1.1, 1.2, or 1.3.</p>	Destroy	Destroy when reference ceases	Hold in agency pending destruction	Unchanged

* **Important:** An exception applies to Aboriginal patient records (refer to Section 1, [Parts 3.6](#) and [3.9](#)).

Index No.	Class of Record	Disposal Action	Sentence*	Custody	Review Status
1.5	<p>Paper Records Reproduced as Digitised Records</p> <p>Refers to the original paper records identified in Index No. 1.1, 1.2 or 1.3 that have been successfully digitised in accordance with the Digitisation Policy and Toolkit.</p> <p>For information on the digitisation of patient records refer to Section 1, Part 3.10.1.</p> <p>Notes</p> <ol style="list-style-type: none"> 1. Paper records that have been digitised but are not eligible for early destruction (refer to Section 1, Part 4.4.2) are to be disposed of in accordance with Index No. 1.1 – 1.3. 2. Where the digitised record is intended to stand in place of the source record, the digitised version must be kept for as long as required under the Schedule. 	Destroy	<p>Reproduced as Digitised Records</p> <p>Destroy source records after reproducing in accordance with Section 1, Part 3.10.1, at least 6 months following digitisation</p>	Hold in agency pending destruction	Updated
1.6	<p>Sample of Individual Patient Records</p> <p>A sample of records in Index No.1.1 – 1.3 must be retained.</p> <p>For further information on determining the significance of individual patient records refer Section 1, Part 4.5.</p> <p>Some factors that may be considered during the re-evaluation process are outlined below.</p>	Archive	Restricted access archive	Transfer to SRO 25 years after reference ceases	Changed

* **Important:** An exception applies to Aboriginal patient records (refer to Section 1, [Parts 3.6](#) and [3.9](#)).

Index No.	Class of Record	Disposal Action	Sentence*	Custody	Review Status
	<p>Sample of Individual Records Continued</p> <p>An individual patient record may be considered to be of business or historical value where it:</p> <ul style="list-style-type: none"> • relates to genetic information that offers insight into the potential for acquiring a condition, or serves as an explanation for a disease (including the likelihood that offspring will inherit a related trait or condition) • concerns diagnoses that are controversial, new or rare • concerns treatment or diagnostic interventions that are considered innovative or controversial • concerns diagnoses and/or treatment that are attracting class action litigation • relates to controversial matters • relates to major obligations or liabilities of health care facilities and/or the State • relates to matters that are attracting community wide interest • patients with significant notifiable diagnoses • otherwise (significantly) impacts or affects the health care facility's functions or operations. 				

* **Important:** An exception applies to Aboriginal patient records (refer to Section 1, [Parts 3.6](#) and [3.9](#)).

2 Inpatient records – extended care facilities

Documents listed under Section 2, Part 1 relate to inpatients in Extended Care Facilities. The date of last access refers to the last time the record was accessed for purposes directly related to the care of the patient. This includes accessing the record for admitted and non-admitted patient services. It is recommended that health care facilities exercise professional judgement in determining the date of last access. Consideration must be given to the reason for access with respect to patient care.

Index No.	Class of Record	Disposal Action	Sentence*	Custody	Review Status
2.1	Discharges from Extended Care Facilities Refers to records of patients discharged from an extended care facility. Refers to documents listed under Section 2, Part 1 .	Destroy	Destroy 10 years after last attendance or date of last access (provided the patient has attained the age of 25 years)	Hold in agency pending destruction	Unchanged
2.2	Records of Deceased Patients Refers to records of patients who have died while in an extended care facility, or who are known to be deceased. Refers to documents listed under Section 2, Part 1 .	Destroy	Destroy 10 years after date of death or date of last access (provided the patient has attained the age of 25 years)	Hold in agency pending destruction	Unchanged
2.3	Extended Care Patient Records: Duplicates Refers to paper duplicates of records identified in Index No. 2.1 or 2.2. Refers to documents listed under Section 2, Part 1 .	Destroy	Destroy when reference ceases	Hold in agency pending destruction	Unchanged
2.4	Paper Records Reproduced as Digitised Records Refers to the original paper records identified in Index No. 2.1 or 2.2 that have been successfully digitised in accordance with the Digitisation Policy and Toolkit and Section 1, Part 3.10.1 of this Schedule.	Destroy	Reproduced as Digitised Records Destroy source records after reproducing in accordance with Section 1, Part 3.10.1 , at least 6 months following digitisation	Hold in agency pending destruction	Updated

* **Important:** An exception applies to Aboriginal patient records (refer to Section 1, [Parts 3.6](#) and [3.9](#)).

3 Non-inpatient records – extended care facilities

The date of last access refers to the last time the record was accessed for purposes directly related to the care of the patient. This includes accessing the record for admitted and non-admitted patient services. It is recommended that health care facilities exercise professional judgement in determining the date of last access. Consideration must be given to the reason for access and whether the purpose was directly related to patient care.

Index No.	Class of Record	Disposal Action	Sentence*	Custody	Review Status
3.1	<p>Non-Inpatient Records – Extended Care Facilities</p> <p>Includes records of day hospitals, day centres and domiciliary care services.</p>	Destroy	Destroy 7 years after last attendance or last official contact between facility and patient or date of last access (provided the patient has attained the age of 25 years)	Hold in agency pending destruction	Unchanged
3.2	<p>Non-Inpatient Records: Duplicates</p> <p>Refers to paper duplicates of records identified in Index No. 3.1.</p>	Destroy	Destroy when reference ceases	Hold in agency pending destruction	Unchanged
3.3	<p>Paper Records Reproduced as Digitised Records</p> <p>Refers to the original paper records identified in Index No.3.1 that have been successfully digitised in accordance with the Digitisation Policy and Toolkit.</p> <p>For information on the digitisation of patient records refer to Section 1, Part 3.10.1.</p>	Destroy	<p>Reproduced as Digitised Records</p> <p>Destroy source records after reproducing in accordance with Section 1, Part 3.10.1, at least 6 months following digitisation</p>	Hold in agency pending destruction	Updated

* **Important:** An exception applies to Aboriginal patient records (refer to Section 1, [Parts 3.6](#) and [3.9](#)).

4 Documents relating to legal claim

Index No.	Class of Record	Disposal Action	Sentence*	Custody	Review Status
4.1	<p>Documents Relating to Legal Claim</p> <p>Includes correspondence between the health facility and solicitors or legal defence organisations regarding a patient of the facility (e.g. subpoenas).</p> <p>It is recommended that such correspondence should be filed separately from the individual patient record.</p>				
4.1.1	If filed with the individual patient record.	Destroy	Sentence according to relevant class of record as defined in Index No. 1.1 – 1.6, 2.1 – 2.4, and 3.1 – 3.3	Hold in agency pending destruction	Unchanged
4.1.2	If not filed with the individual patient record.	Destroy	Destroy 15 years after resolution of legal matter (provided the patient has attained the age of 25 years)	Hold in agency pending destruction	Unchanged

* **Important:** An exception applies to Aboriginal patient records (refer to Section 1, [Parts 3.6](#) and [3.9](#)).

5 Special categories of individual patient records

The date of last access refers to the last time the record was accessed for purposes directly related to the care of the patient. This includes accessing the record for admitted and non-admitted patient services. It is recommended that health care facilities exercise professional judgement in determining the date of last access. Consideration must be given to the reason for access and whether the purpose was directly related to patient care.

Index No.	Class of Record	Disposal Action	Sentence*	Custody	Review Status
5.1	<p>In Vitro Fertilisation Records and Artificial Insemination Records</p> <p>Individual patient records of each person or family unit which include consent to In Vitro Fertilisation (IVF) or Artificial Insemination (AI), and use of semen, ova or embryos and the withdrawal of consent for such processes.</p>	Archive	Restricted access archive	Transfer to SRO 25 years after reference ceases	Unchanged
5.2	<p>In Vitro Fertilisation and Artificial Insemination Register</p> <p>Includes paper and electronic registers held by agencies of patients that have received or are receiving IVF and AI treatment from public health care facilities.</p> <p>Electronic registers may be held within WA Health computerised patient administration systems (i.e. HCARE, TOPAS and webPAS).</p>	<p>Paper</p> <p>Archive</p> <p>Electronic</p> <p>Archive within Agency</p>	<p>Paper</p> <p>Restricted access archive</p> <p>Electronic</p> <p>Restricted access archive</p>	<p>Paper</p> <p>Transfer to SRO 25 years after reference ceases</p> <p>Electronic</p> <p>Hold in agency</p>	Unchanged

* **Important:** An exception applies to Aboriginal patient records (refer to Section 1, [Parts 3.6](#) and [3.9](#)).

Index No.	Class of Record	Disposal Action	Sentence*	Custody	Review Status
5.3	<p>Adoption Records</p> <p>This class refers to records concerning the adoption of individuals, encompassing patient information relating to the act of adoption.</p>	Archive	Restricted access archive	Transfer to SRO 25 years after reference ceases	Unchanged
5.4	<p>Sexual Assault Records</p> <p>Refers to the records of Sexual Assault Referral Clinics where documentation is maintained separately from the individual patient record.</p> <p>Where the documents are filed in the individual patient record, dispose in accordance with appropriate record classes refer to Index No. 1.1 – 1.3, 2.1 – 2.2, or 3.1.</p>	Destroy	Destroy 25 years after action completed (provided the patient has attained the age of 25 years)	Hold in agency pending destruction	Unchanged
5.5	<p>Case Management Program Records</p> <p>Case Management Program (CMP) Records include case notes, reports and correspondence relating to clients of the Department Case Management Unit.</p> <p>Note</p> <p>1. CMP records may be destroyed upon fulfilment of the minimum retention period, regardless of Aboriginal status as noted in Section 1, Part 3.9.</p>				

* **Important:** An exception applies to Aboriginal patient records (refer to Section 1, [Parts 3.6](#) and [3.9](#)).

Index No.	Class of Record	Disposal Action	Sentence*	Custody	Review Status
5.5.1	CMP Records (Paper) Includes all paper records that originate from the electronic record. Excludes all correspondence/reports, both internal and external, not originating from the electronic record.	Destroy	Destroy 3 years after case is concluded/closed	Hold in agency pending destruction	Unchanged
5.5.2	CMP Records (Electronic Files) Includes all information originating from the electronic record.	Destroy	Destroy 7 years after case is concluded/closed	Hold in agency pending destruction	Unchanged
5.5.3	CMP Records (Correspondence/Reports) Includes all correspondence/reports both internal and external not originating from the electronic record.	Destroy	Destroy 7 years after case is concluded/closed	Hold in agency pending destruction	Unchanged
5.5.4	CMP Records (Register) The Register is held in electronic form and includes a list of all clients, their registration details and the period for which the CMP has contact with them.	Archive	Restricted access archive	Transfer hard copy print-out to SRO 25 years after reference ceases	Unchanged
5.6	Poisons Information Centre Records (PM238) Refers to the Poisons Information Centre Call Record (PM238) where documentation is maintained separately from the hospital patient record.	Destroy	Destroy 7 years after last official contact between the facility and patient, including access on behalf of the patient (provided the patient has attained the age of 25 years)	Hold in agency pending destruction	Unchanged

* **Important:** An exception applies to Aboriginal patient records (refer to Section 1, [Parts 3.6](#) and [3.9](#)).

Index No.	Class of Record	Disposal Action	Sentence*	Custody	Review Status
	<p>Poisons Information Centre Records (PM238) Continued</p> <p>Where the document(s) are filed in the individual patient record, dispose in accordance with appropriate record classes refer to Index No. 1.1 – 1.3, 2.1 – 2.2, or 3.1.</p>				
5.7	<p>Research Records</p> <p>The National Health and Medical Research Council (NHMRC) Guidelines should be consulted for further details or clarification.</p>				
5.7.1	<p>Patient or Subject Research Records</p> <p>Refers to records (including laboratory results, reports, questionnaires and surveys) obtained from consenting patients or subjects for the specific purpose of researching a project, theory or trial.</p>	Destroy	<p>For questionnaires and surveys, destroy 7 years after completion of project</p> <p>For laboratory results, destroy as per National Health and Medical Research Council Guidelines</p>	Hold in agency pending destruction	Unchanged
5.7.2	<p>Records of Consent or Authorisation</p> <p>Refers to records of consent or authorisation for the use of patient's or subject's results in research.</p>	Destroy	Destroy 7 years after completion of project	Hold in agency pending destruction	Unchanged
5.7.3	<p>Research Requests</p> <p>Refers to documented requests to perform research.</p>	Destroy	Destroy 10 years after completion of research or after official refusal of research request	Hold in agency pending destruction	Unchanged

* **Important:** An exception applies to Aboriginal patient records (refer to Section 1, [Parts 3.6](#) and [3.9](#)).

Index No.	Class of Record	Disposal Action	Sentence*	Custody	Review Status
5.8	<p>HealthDirect Telephone Triage Service Records</p> <p>Refers to the HealthDirect Telephone Triage Service where documentation is stored electronically.</p> <p>Should documentation be included in the individual patient record, dispose in accordance with appropriate record classes refer to Index No. 1.1 – 1.3, 2.1 – 2.2, or 3.1.</p>	Destroy	Destroy 7 years after initial contact (provided the patient has attained the age of 25 years)	Hold in agency pending destruction	Unchanged
5.9	<p>DonateWest Records</p> <p>DonateWest records include case notes, operation reports, consent documentation, pathology results and correspondence relating to organ and tissue donors in WA.</p>	Destroy	Destroy 75 years after date of death	Hold in agency pending destruction	Unchanged
5.10	<p>BreastScreen WA Program</p> <p>Refers to screening x-ray films created by BreastScreen WA only.</p>	Destroy	Destroy 7 years after date of creation of x-ray, provided the last three screening x-ray films are retained for each client	Hold in agency pending destruction	Unchanged
5.11	<p>Records of Individuals that have not attended a Health Care Facility as a Patient/Client</p> <p>This category applies to documents received by a health care facility about individuals that have not subsequently attended as a patient/client. Examples include general correspondence, referral forms and pathology reports.</p>	Destroy	Destroy 12 months after date of receipt of document	Hold in agency pending destruction	Unchanged

* **Important:** An exception applies to Aboriginal patient records (refer to Section 1, [Parts 3.6](#) and [3.9](#)).

Index No.	Class of Record	Disposal Action	Sentence*	Custody	Review Status
5.12	<p>Paper Records Reproduced as Digitised Records</p> <p>Refers to the original paper records identified in Index No.5.1 – 5.11 that have been successfully digitised in accordance with the Digitisation Policy and Toolkit.</p> <p>For information on the digitisation of patient records refer to Section 1, Part 3.10.1.</p>	Destroy	<p>Reproduced as Digitised Records</p> <p>Destroy source records after reproducing in accordance with Section 1, Part 3.10.1, at least 6 months following digitisation</p>	Hold in agency pending destruction	Addition

* **Important:** An exception applies to Aboriginal patient records (refer to Section 1, [Parts 3.6](#) and [3.9](#)).

6 Community health records

Records relating to clients of community health centres, child health centres and schools. The date of last access refers to the last time the record was accessed for purposes directly related to the care of the client. This includes accessing the record for client admissions and 'non-admitted patient' services. It is recommended that community health facilities exercise professional judgement in determining the date of last access. Consideration must be given to the reason for access and whether the purpose was directly related to patient care.

Index No.	Class of Record	Disposal Action	Sentence*	Custody	Review Status
6.1	Child Health Records				
6.1.1	Notification of Case Attended (MR 15) An electronic version of this form is now widely used. Should a hard copy (white) be provided to child health nurses from health care facilities it is filed with the Child Health Record (CHS 560).	Destroy	Destroy 7 years after the child has attained the age of 18 years	Hold in agency pending destruction	Changed
6.1.2	Child Health Birth Register (CHS 35)	Destroy	Destroy 7 years after the youngest child in the register has attained the age of 18 years	Hold in agency pending destruction	Unchanged
6.1.3	Child Health Record (CHS 560) Note 1. Excludes Adoption Records – these must be retained permanently (refer to Index No. 5.3).	Destroy	Destroy 7 years after the child has attained the age of 18 years	Hold in agency pending destruction	Changed

* **Important:** An exception applies to Aboriginal patient records (refer to Section 1, [Parts 3.6](#) and [3.9](#)).

Index No.	Class of Record	Disposal Action	Sentence*	Custody	Review Status
6.1.4	Temporary Child Health Record for Transfers and Visitors (CHS 560A) <i>Formerly known Temporary Record for Transfers and Visitors (CHS 560A)</i> This form complements and is filed with the Child Health Record (CHS 560)	Destroy	Destroy 7 years after the child has attained the age of 18 years	Hold in agency pending destruction	Changed
6.1.5	Family Health Record (CHS 560B) This form complements and is filed with Child Health Record (CHS 560)	Destroy	Destroy 7 years after the child has attained the age of 18 years	Hold in agency pending destruction	Addition
6.1.6	Maternal Health Program (CHS18) This card system is no longer used. This class of record remains in the Schedule as the minimum retention requirements may not have expired.	Destroy	Destroy 7 years after the birth of child providing the mother has attained the age of 25 years	Hold in agency pending destruction	Unchanged
6.1.7	Progress Notes (CHS 017) These notes can be attached as an addendum to CHS 560 or CHS 560B if additional space for progress notes is needed.	Destroy	Destroy 7 years after the child has attained the age of 18 years	Hold in agency pending destruction	Addition
6.1.8	Referral Form 6-8 Weeks Motor Development (CHS 575) Retain duplicate copy with the child health record (CHS 560)	Destroy	Destroy 7 years after the child has attained the age of 18 years	Hold in agency pending destruction	Addition

* **Important:** An exception applies to Aboriginal patient records (refer to Section 1, [Parts 3.6](#) and [3.9](#)).

Index No.	Class of Record	Disposal Action	Sentence*	Custody	Review Status
6.1.9	Child Health Service Calling Card (CHS 014) Retain duplicate copy with the child health record (CHS 560)	Destroy	Destroy 7 years after the child has attained the age of 18 years	Hold in agency pending destruction	Addition
6.2	Enhanced Aboriginal Child Health Schedule Records Note 1. Excludes Aboriginal records subject to Section 1, Part 3.6 of this Schedule.				
6.2.1	Child History (CHS 703) This form complements and is filed with Child Health Record (CHS 560).	Destroy	Destroy 7 years after the child has attained the age of 18 years	Hold in agency pending destruction	Addition
6.2.2	Strengths and Risk Assessment (CHS 704) This form complements and is filed with Child Health Record (CHS 560).	Destroy	Destroy 7 years after the child has attained the age of 18 years	Hold in agency pending destruction	Addition
6.2.3	0-5 Years Summary Sheet This form complements and is filed with Child Health Record (CHS 560).	Destroy	Destroy 7 years after the child has attained the age of 18 years	Hold in agency pending destruction	Addition

* **Important:** An exception applies to Aboriginal patient records (refer to Section 1, [Parts 3.6](#) and [3.9](#)).

Index No.	Class of Record	Disposal Action	Sentence*	Custody	Review Status
6.2.4	<p><u>Community Health Assessment Checklists:</u></p> <p>Antenatal Contact (CHS 701)</p> <p>First Contact (CHS 702)</p> <p>8 Week Contact (CHS 705-1)</p> <p>4 Month Contact (CHS 706)</p> <p>6 Month Contact (CHS 707)</p> <p>8 Month Contact (CHS 708)</p> <p>12 Month Contact (CHS 709-1)</p> <p>18 Month Contact (CHS 710)</p> <p>2 Year Contact (CHS 711-1)</p> <p>2.5 Year Contact (CHS 712)</p> <p>3 Year Contact (CHS 713-1)</p> <p>3.5 Year Contact (CHS 714)</p> <p>4 Year Contact (CHS 715-1)</p> <p>4.5 Year Contact (CHS 716)</p> <p>Used for community health assessments as part of a targeted Aboriginal Health program. This form complements and is filed with Child Health Record (CHS 560).</p>	Destroy	Destroy 7 years after the child has attained the age of 18 years	Hold in agency pending destruction	Addition

* **Important:** An exception applies to Aboriginal patient records (refer to Section 1, [Parts 3.6](#) and [3.9](#)).

Index No.	Class of Record	Disposal Action	Sentence*	Custody	Review Status
6.2.5	<p><u>Medical Officer Examination Forms</u></p> <p>8 Week Exam: Medical Officer (CHS 705-2)</p> <p>12 Month Exam: Medical Officer (CHS 709-2)</p> <p>2 Year Exam: Medical Officer (CHS 711-2)</p> <p>3 Year Exam: Medical Officer (CHS 713-2)</p> <p>4 Year Exam: Medical Officer (CHS 715-2)</p> <p>5 Year Exam: Medical Officer (CHS 717)</p> <p>Used for Medical Officer Assessments as part of a targeted Aboriginal Health program. This form complements and is filed with Child Health Record (CHS 560).</p>	Destroy	Destroy 7 years after the child has attained the age of 18 years	Hold in agency pending destruction	Addition
6.3	School Health Records				
6.3.1	<p>CHS 50 Accident/Injury Illness Record</p> <p>This form is no longer in use.</p>	Destroy	Destroy when client has attained the age of 25 years, if 7 years after last date of access	Hold in agency pending destruction	Changed

* **Important:** An exception applies to Aboriginal patient records (refer to Section 1, [Parts 3.6](#) and [3.9](#)).

Index No.	Class of Record	Disposal Action	Sentence*	Custody	Review Status
6.3.2	CHS 142 Referral to Community Health Nurse	Destroy	Can destroy 1 year after the completion of primary or secondary schooling, as per CHS 409 or CHS 410. However, where there is reasonable expectation of legal implications, retain until client has attained the age of 25 years, if 7 years after last attendance or last date of access	Hold in agency pending destruction	Changed
6.3.3	CHS 143 Class List The class list is a tool used to manage the tasks associated with school entry health assessments against the children's names, e.g. form sent to parent/guardian, consent provided, screening tests completed, referral progressed etc.	Destroy	Destroy 1 year after cohort completes primary schooling	Hold in agency pending destruction	Changed
6.3.4	CHS 409 Primary School Health Record <i>This may also be known as School Entry Health Assessment form. Formerly known as Kindy/Pre-primary/Year 1 School Health Record.</i> CHS 409 consists of two parts: Part A – School entry, health history, parent consent and progress notes; and, Part B – Health Assessment Results (health service copy).	Destroy	Can destroy 1 year after the completion of primary schooling. However, where there is a reasonable expectation of legal implications, retained until client has attained the age of 25 years, if 7 years after last access	Hold in agency pending destruction	Changed

* **Important:** An exception applies to Aboriginal patient records (refer to Section 1, [Parts 3.6](#) and [3.9](#)).

Index No.	Class of Record	Disposal Action	Sentence*	Custody	Review Status
6.3.5	CHS 410 High School Health Record	Destroy	Can destroy 1 year after the completion of secondary schooling. However, where there is a reasonable expectation of legal implications, retain until client has attained the age of 25 years, if 7 years after last attendance or last date of access	Hold in agency pending destruction	Unchanged
6.3.6	CHS 413 Education Support School/Centre Record This form is no longer in use.	Destroy	Can destroy 1 year after the completion of secondary schooling. However, where there is legal implications, retain until client has attained the age of 25 years, if 7 years after last attendance or last date of access	Hold in agency pending destruction	Changed
6.3.7	CHS 412 School Health Progress Notes This form is used as an addendum to: <ul style="list-style-type: none"> • Primary School Health Record (CHS 409) • High School Health Record (CHS 410). 	Destroy	Destroy as per Primary School Health Record (CHS 409) or High School Health Record (CHS 410)	Hold in agency pending destruction	Unchanged
6.3.8	CHS 416 Year 6 Vision Screening Form This form no longer in use.	Destroy	Destroy 1 year after last attendance or date of last access, or when client completes primary schooling	Hold in agency pending destruction.	Unchanged

* **Important:** An exception applies to Aboriginal patient records (refer to Section 1, [Parts 3.6](#) and [3.9](#)).

Index No.	Class of Record	Disposal Action	Sentence*	Custody	Review Status
6.3.9	CHS 417 School Health Record Transfer Record When children move to a new school, health records may follow, especially if there has been an issue highlighted. CHS 417 is a register of records which are moved in or out of the health region.	Do not destroy	List to be retained	Hold in agency	Addition
6.3.10	CHS 418 Information to Ophthalmologist from Community Health Use when making a referral to an ophthalmologist via a general practitioner.	Destroy	Destroy as per Primary School Health Record (CHS 409) or High School Health Record (CHS 410)	Hold in agency pending destruction	Addition
6.3.11	CHS 419 Weight Assessment Record CHS 419 (A) used for girls CHS 419 (B) used for boys.	Destroy	Destroy as per Primary School Health Record (CHS 409) or High School Health Record (CHS 410)	Hold in agency pending destruction	Addition
6.3.12	CHS 421 Psychological Risk Assessment (HEADSS) Part A used for initial assessment Part B used for follow-up assessments.	Destroy	Destroy as per High School Health Record (CHS 410)	Hold in agency pending destruction	Addition
6.3.13	CHS 422 Body Diagram	Destroy	Destroy as per Primary School Health Record (CHS 409) or High School Health Record (CHS 410)	Hold in agency pending destruction	Addition

* **Important:** An exception applies to Aboriginal patient records (refer to Section 1, [Parts 3.6](#) and [3.9](#)).

Index No.	Class of Record	Disposal Action	Sentence*	Custody	Review Status
6.3.14	CHS 423 Ear Health Assessment Results Used for ear health assessment as part of a targeted Aboriginal Health program.	Destroy	Destroy as per Primary School Health Record (CHS 409) or High School Health Record (CHS 410)	Hold in agency pending destruction	Addition
6.4	Other Community Health Records				
6.4.1	Centralised Client Health Record Where the centre has an integrated client record to which all practitioners contribute.	Destroy	Destroy 7 years after last attendance or after date of last access (provided the client has attained the age of 25 years)	Hold in agency pending destruction	Unchanged
6.4.2	CHS 424 Children in Care Health Assessment and Improvement Plan	Destroy	Destroy when client has attained the age of 25 years, if 7 years after last attendance or last date of access	Hold in agency pending destruction	Addition
6.4.3	CHS 663 Referral from Community Health <i>Formerly known as Confidential Referral form.</i>	Destroy	Destroy 7 years after last attendance or after date or last access (provided the client has attained the age of 25 years). Adult records are retained for 10 years after last attendance or after date of late access	Hold in agency pending destruction	Unchanged
6.4.4	CHS 414 Children's Day Care Form This form is no longer used and was discontinued from 1994 onwards. This class of record remains in the Schedule as records associated with legal implications may have been retained.	Destroy	Destroy 1 year after client has attained the age of 5 years	Hold in agency pending destruction	Unchanged

* **Important:** An exception applies to Aboriginal patient records (refer to Section 1, [Parts 3.6](#) and [3.9](#)).

Index No.	Class of Record	Disposal Action	Sentence*	Custody	Review Status
6.4.5	Discipline Specific Client Records Where a record is not compiled in an integrated record and practitioners retain discipline specific records.	Destroy	Destroy 7 years after last attendance or after date of last access (provided the client has attained the age of 25 years)	Hold in agency pending destruction	Unchanged
6.4.6	Diary (Work) Work diary containing information which identifies an individual client, including details of client appointments, assessments, telephone conversations etc.	Destroy	Destroy 7 years after date of last entry	Hold in agency pending destruction	Unchanged
6.5	Health Centre and Immunisation Records				
6.5.1	Confidential Records (CHS 28) <i>Formerly known as 'Registered Records'</i> Contain sensitive information regarding abuse, family disharmony, developmental disorders, pregnancy etc.	Destroy	Destroy 7 years after last attendance or after date of last access (provided the client has attained the age of 25 years)	Hold in agency pending destruction	Unchanged

* **Important:** An exception applies to Aboriginal patient records (refer to Section 1, [Parts 3.6](#) and [3.9](#)).

Index No.	Class of Record	Disposal Action	Sentence*	Custody	Review Status
6.5.2	<p>Immunisation Record/Request Card (CHS 631)</p> <p>This form is no longer used and has been replaced by forms identified in Index No. 6.5.3 – 6.5.6 including:</p> <ul style="list-style-type: none"> • Aboriginal Child Vaccination Record Card (HP2737) • Non-Aboriginal Child Vaccination Record Card (HP1059) • Adult Vaccination Catch-up Record Card (HP3234) • Child Vaccination Catch-up Record Card (HP 3235). 	Destroy	Sentence according to relevant class of record as defined in Index No. 6.2.3 – 6.2.6	Hold in agency pending destruction	Unchanged
6.5.3	Aboriginal Child Vaccination Record Card (HP 2737)	Destroy	Destroy 10 years after last attendance or after date of last access (provided the client has attained the age of 25 years)	Hold in agency pending destruction	Unchanged
6.5.4	Non-Aboriginal Child Vaccination Record Card (HP 1059)	Destroy	Destroy 10 years after last attendance or after date of last access (provided the client has attained the age of 25 years)	Hold in agency pending destruction	Unchanged
6.5.5	Adult Vaccination Catch-up Record Card (HP 3234)	Destroy	Destroy 10 years after last attendance or after date of last access (provided the client has attained the age of 25 years)	Hold in agency pending destruction	Unchanged

* **Important:** An exception applies to Aboriginal patient records (refer to Section 1, [Parts 3.6](#) and [3.9](#)).

Index No.	Class of Record	Disposal Action	Sentence*	Custody	Review Status
6.5.6	Child Vaccination Catch-up Record Card (HP 3235)	Destroy	Destroy 10 years after last attendance or after date of last access (provided the client has attained the age of 25 years)	Hold in agency pending destruction	Unchanged
6.6	<p>Paper Records Reproduced as Digitised Records</p> <p>Refers to the original paper records identified in Index No.6.1 to 6.5.6 that have been successfully digitised in accordance with the Digitisation Policy and Toolkit.</p> <p>For information on the digitisation of patient records refer to Section 1, Part 3.10.1.</p>	Destroy	<p>Reproduced as Digitised Records</p> <p>Destroy source records after reproducing in accordance with Section 1, Part 3.10.1, at least 6 months following digitisation</p>	Hold in agency pending destruction	Addition

* **Important:** An exception applies to Aboriginal patient records (refer to Section 1, [Parts 3.6](#) and [3.9](#)).

7 Dental records

Index No.	Class of Record	Disposal Action	Sentence*	Custody	Review Status
7.1	<p>Adult Dental Examination Records</p> <p>Refers to Dental Health Services patient records.</p>	Destroy	Destroy 7 years after last attendance, last official contact between facility and client or date of last access (provided the client has attained the age of 25 years)	Hold in agency pending destruction	Unchanged
7.2	<p>Child Dental Examination Records</p> <p>Refers to Dental Health Services patient records.</p>	Destroy	Destroy 7 years after last attendance, last official contact between facility and client or date of last access (provided the client has attained the age of 25 years)	Hold in agency pending destruction	Unchanged
7.3	<p>Paper Records Reproduced as Digitised Records</p> <p>Refers to the original paper records identified in Index No.7.1 to 7.2 that have been successfully digitised in accordance with the Digitisation Policy and Toolkit.</p> <p>For information on the digitisation of patient records refer to Section 1, Part 3.10.1.</p>	Destroy	<p>Reproduced as Digitised Records</p> <p>Destroy source records after reproducing in accordance with Section 1, Part 3.10.1, at least 6 months following digitisation</p>	Hold in agency pending destruction	Addition

* **Important:** An exception applies to Aboriginal patient records (refer to Section 1, [Parts 3.6](#) and [3.9](#)).

8 Microform documents

Refers to records reproduced on microform and related affidavits on paper or in microform.

Index No.	Class of Record	Disposal Action	Sentence*	Custody	Review Status
8.1	Microform Master Copies				
8.1.1	Microform Records of Acute Hospital Discharged Patients, Outpatients and Emergency Medicine Records Refers to microform master copies of original paper records identified in Index No. 1.1 and 1.3.	Destroy	Destroy 15 years after last attendance or date of last access (provided the patient has attained the age of 25 years)	Hold in agency pending destruction	Unchanged
8.1.2	Microform Records of Acute Hospital Deceased Patients Refers to microform master copies of original paper records identified in Index No. 1.2.	Destroy	Destroy 10 years after date of death or date of last access (provided the patient has attained the age of 25 years)	Hold in agency pending destruction	Unchanged
8.1.3	Microform Records of Extended Care Discharged Inpatients Refers to microform master copies of original paper records identified in Index No. 2.1.	Destroy	Destroy 10 years after last attendance or date of last access (provided the patient has attained the age of 25 years)	Hold in agency pending destruction	Unchanged
8.1.4	Microform Records of Extended Care Deceased Patients Refers to microform master copies of original paper records identified in Index No. 2.2.	Destroy	Destroy 10 years after date of death or date of last access (provided the patient has attained the age of 25 years)	Hold in agency pending destruction	Unchanged

* **Important:** An exception applies to Aboriginal patient records (refer to Section 1, [Parts 3.6](#) and [3.9](#)).

Index No.	Class of Record	Disposal Action	Sentence*	Custody	Review Status
8.2	Microform Master Copies of Individual Patient Records: Superseded Copies Refers to cases where the information has been copied onto a later master copy in a manner that preserves its integrity.	Destroy	Destroy when superseded	Hold in agency pending destruction	Unchanged
8.3	Affidavits Relating to Microfilming Refers to paper and microform copies.	Destroy	Destroy at same time as master microform to which they relate	Hold in agency pending destruction	Unchanged

* **Important:** An exception applies to Aboriginal patient records (refer to Section 1, [Parts 3.6](#) and [3.9](#)).

9 Patient indexes, registers and lists

Index No.	Class of Record	Disposal Action	Sentence*	Custody	Review Status
9.1	<p>Patient Master Index</p> <p>The Patient Master Index (PMI) records the names of patients who have been admitted to a public hospital, extended care unit or community health centre.</p> <p>It is the key to locating an individual patient record in a numerical filing system, by providing a link between the name of the patient and the facility's medical record number.</p> <p>The PMI contains details such as the patient's name, medical record number, date of birth, gender, address and other relevant details.</p> <p>The PMI may exist as a paper-based card index or electronically within a computerised patient administration system. Three patient administration systems are operational with WA Health, these are HCARE, TOPAS and webPAS.</p> <p>The PMI may also be known as a Central Patient Index (CPI).</p>	<p>Paper</p> <p>Archive</p> <p>Electronic</p> <p>Archive within Agency</p>	<p>Restricted access archive</p> <p>Restricted access archive</p>	<p>Transfer card index to SRO 25 years after reference ceases</p> <p>Hold within agency and preserve PMI in accordance with SRC Standard 8 and the Department's policies (refer to Section 1, Part 3.1.1)</p>	Unchanged

* **Important:** An exception applies to Aboriginal patient records (refer to Section 1, [Parts 3.6](#) and [3.9](#)).

Index No.	Class of Record	Disposal Action	Sentence*	Custody	Review Status
9.1.1	<p>Patient Index: Superseded or Duplicate Copy</p> <p>Refers to duplicates or superseded microform or print-out copies of the PMI where all information is incorporated into a subsequent copy.</p>	Destroy	Destroy when reference ceases	Hold in agency pending destruction	Unchanged
9.2	<p>Disease and Operation Index</p> <p>This Index records, for each disease/condition and operation or procedure code number, selected items of patient information for each inpatient having that diagnosis, or recorded as having undergone that operation or procedure in the period covered by that index.</p> <p>The Index contains details such as the patient's medical record number, name, gender, age, date of admission, length of stay, discharge status and destination, responsible doctor or unit (name or code identifier), ward and disease/condition and operation codes relevant to each episode of care.</p> <p>The Disease and Operation Index may exist as a paper-based card index or electronically within a computerised patient administration system (i.e. HCARE, TOPAS, webPAS).</p>	<p>Paper Archive</p> <p>Electronic Archive within Agency</p>	<p>Restricted access archive</p> <p>Restricted access archive</p>	<p>Transfer card index to SRO 25 years after reference ceases</p> <p>Hold within agency and preserve Disease and Operation Index in accordance with SRC Standard 8 and the Department's policies (refer to Section 1, Part 3.1.1)</p>	Unchanged

* **Important:** An exception applies to Aboriginal patient records (refer to Section 1, [Parts 3.6](#) and [3.9](#)).

Index No.	Class of Record	Disposal Action	Sentence*	Custody	Review Status
9.3	<p>Physicians Index</p> <p>For each medical practitioner with admitting rights, this Index (electronic or manual) records the inpatients attended by that practitioner during the period covered by the Index.</p> <p>Details recorded include the patient's name, medical record number, and all disease, condition, operation and procedure codes related to a particular admission.</p> <p>Information may also include gender, age, date of admission, length of stay, discharge status and destination.</p>	Destroy	Destroy when reference ceases	Hold in agency pending destruction	Unchanged
9.4	<p>Number Register</p> <p>A register (electronic or manual) used to list the unit record numbers in numerical order and, as each number is issued, records the name of the patient to whom that number has been issued. Information includes the date of issue, the patient's date of birth and other information.</p>				

* **Important:** An exception applies to Aboriginal patient records (refer to Section 1, [Parts 3.6](#) and [3.9](#)).

Index No.	Class of Record	Disposal Action	Sentence*	Custody	Review Status
9.4.1	Number Register where the PMI (Index No. 9.1) does not exist and the Number Register provides an alternative source of information.	<p>Paper Archive</p> <p>Electronic Archive within Agency</p>	<p>Restricted access archive</p> <p>Restricted access archive</p>	<p>Transfer card index to SRO 25 years after reference ceases</p> <p>Hold within agency and preserve Number Register in accordance with SRC Standard 8 and the Department's policies (refer to Section 1, Part 3.1.1)</p>	Unchanged
9.4.2	Number Register where information in the Number Register is duplicated in the PMI (Index No. 9.1) and the PMI exists.	Destroy	Destroy when superseded or reference ceases	Hold in agency pending destruction	Unchanged

* **Important:** An exception applies to Aboriginal patient records (refer to Section 1, [Parts 3.6](#) and [3.9](#)).

Index No.	Class of Record	Disposal Action	Sentence*	Custody	Review Status
9.5	<p>Admission Register</p> <p>This lists, in date order, each inpatient admitted. Information will include date of admission and name of patient. Information may also include time of admission, medical record number, address, gender, date of birth, next of kin, admitting diagnosis, discharge date and length of stay.</p> <p>The Admission Register may exist as a paper-based bound or loose-leaf volume or electronically within a computerised patient administration system. Three patient administration systems are operational within WA Health, these are HCARE, TOPAS and webPAS.</p>	<p>Paper</p> <p>Archive</p> <p>Electronic</p> <p>Archive within Agency</p>	<p>Restricted access archive</p> <p>Restricted access archive</p>	<p>Transfer volume to SRO 25 years after reference ceases</p> <p>Hold within agency and preserve Admission Register in accordance with SRC Standard 8 and the Department's policies (refer to Section 1, Part 3.1.1)</p>	Unchanged
9.6	<p>Discharge Register</p> <p>Register listing in date order each inpatient discharged. Information includes date of discharge and name. Additional information may include medical record number, discharge diagnosis and length of stay.</p>				

* **Important:** An exception applies to Aboriginal patient records (refer to Section 1, [Parts 3.6](#) and [3.9](#)).

Index No.	Class of Record	Disposal Action	Sentence*	Custody	Review Status
	<p>Discharge Register Continued</p> <p>The Discharge Register may exist as a paper-based bound or loose-leaf volume or electronically within a patient administration system (i.e. HCARE, TOPAS or webPAS).</p> <p>Retain the Discharge Register in accordance with Index No. 9.6.1 if discharge information is not entered in Index No. 9.5 Admission Register. Where the Admission Register contains discharge information, the Discharge Register may be destroyed when reference ceases in accordance with Index No. 9.6.2.</p>				
9.6.1	Discharge Register where the Admission Register (Index No. 9.5) does not exist and the Number Register provides an alternative source of information or where Admission Register does not contain discharge information.	<p>Paper Archive</p> <p>Electronic Archive within Agency</p>	<p>Restricted access archive</p> <p>Restricted access archive</p>	<p>Transfer volume to SRO 25 years after reference ceases</p> <p>Hold within agency and preserve Discharge Register in accordance with SRC Standard 8 and the Department's policies (refer to Section 1, Part 3.1.1)</p>	Unchanged

* **Important:** An exception applies to Aboriginal patient records (refer to Section 1, [Parts 3.6](#) and [3.9](#)).

Index No.	Class of Record	Disposal Action	Sentence*	Custody	Review Status
9.6.2	Discharge Register where the information in the Discharge Register is duplicated in the Admission Register (Index No. 9.5) and the Admission Register exists.	Destroy	Destroy when reference ceases	Hold in agency pending destruction	Unchanged
9.7	<p>Emergency Department Register Information includes date of attendance and name of patient. Information may include time of attendance, patient gender, age, address, reason for attendance (e.g. diagnosis, symptom, injury) and, where available, outcome of follow-up arrangement.</p> <p>The Emergency Department Register may exist as a paper-based bound or loose-leaf volume or electronically within a computerised patient administration system. Four patient administration systems are operational within WA Health, these are Emergency Discharge Information System (EDIS), HCARE, TOPAS and webPAS.</p>	<p>Paper Archive</p> <p>Electronic Archive within Agency</p>	<p>Restricted access archive</p> <p>Restricted access archive</p>	<p>Transfer volume to SRO 25 years after reference ceases</p> <p>Hold within agency and preserve Register in accordance with SRC Standard 8 and the Department's policies (refer to Section 1, Part 3.1.1)</p>	Unchanged
9.8	<p>Labour Ward (Birth) Register A register which lists in date order each birth occurring in the hospital. Information on the register may include a listing of the date and time of birth, mother's name, gender of baby and names of medical and nursing staff in attendance.</p>	Paper Archive	Restricted access archive	Transfer volume to SRO 25 years after reference ceases	Unchanged

* **Important:** An exception applies to Aboriginal patient records (refer to Section 1, [Parts 3.6](#) and [3.9](#)).

Index No.	Class of Record	Disposal Action	Sentence*	Custody	Review Status
	<p>Labour Ward (Birth) Register Continued</p> <p>Information may also include the mother's record number, age and address.</p> <p>The Labour Ward (Birth) Register may exist as a paper-based bound or loose-leaf volume or electronically within a computerised patient administration system. Four patient administration systems are operational within WA Health, these are HCARE, STORK, TOPAS and webPAS.</p>	<p>Electronic Archive within Agency</p>	<p>Restricted access archive</p>	<p>Hold within agency and preserve Register in accordance with SRC Standard 8 and the Department's policies (refer to Section 1, Part 3.1.1)</p>	<p>Unchanged</p>
9.9	<p>Death Register</p> <p>This lists, in date order, each death occurring in the facility.</p> <p>Information will include date and time of death and name of patient. Information may include patient's gender and age, cause of death and name of medical officer.</p> <p>The Death Register may exist as a paper-based bound or loose-leaf volume or electronically within a computerised patient administration system. Three patient administration systems are operational within WA Health; these are HCARE, TOPAS and webPAS.</p>	<p>Paper Archive</p> <p>Electronic Archive within Agency</p>	<p>Restricted access archive</p> <p>Restricted access archive</p>	<p>Transfer volume to SRO 25 years after reference ceases</p> <p>Hold within agency and preserve Register in accordance with SRC Standard 8 and the Department's policies (refer to Section 1, Part 3.1.1)</p>	<p>Unchanged</p>

* **Important:** An exception applies to Aboriginal patient records (refer to Section 1, [Parts 3.6](#) and [3.9](#)).

Index No.	Class of Record	Disposal Action	Sentence*	Custody	Review Status
9.10	<p>Operations or Theatre Register</p> <p>This lists in date and time order each operation or procedure carried out in the theatre.</p> <p>Information will include date, serial number of operation, time, patient's name, gender, age, record number, diagnosis and operative procedure, names of surgeon and anaesthetist, operative or anaesthetic complications and remarks.</p> <p>The Operations or Theatre Register may exist as a paper-based bound or loose-leaf volume or electronically within a computerised patient administration system or clinical information system. Three systems are operational within WA Health; these are Theatre Management System (TMS), TOPAS and webPAS.</p>	<p>Paper Archive</p> <p>Electronic Archive within Agency</p>	<p>Restricted access archive</p> <p>Restricted access archive</p>	<p>Transfer volume to SRO 25 years after reference ceases</p> <p>Hold within agency and preserve Register in accordance with the Department's policies (refer to Section 1, Part 3.1.1)</p>	Unchanged
9.11	<p>Cancer Register Documents</p>				
9.11.1	<p>Cancer Register Database</p> <p>Electronic listing of Cancer registrations from 1982 to present.</p>	Archive within Agency	Restricted access archive	Hold within agency and preserve register in accordance with the Department's policies (refer to Section 1, Part 3.1.1)	Unchanged

* **Important:** An exception applies to Aboriginal patient records (refer to Section 1, [Parts 3.6](#) and [3.9](#)).

Index No.	Class of Record	Disposal Action	Sentence*	Custody	Review Status
9.11.2	Documents Filed in Individual Patient Records	Destroy	Sentence according to 1.1, 1.2, 2.1, 2.2 or 3.1	Hold in agency pending destruction	Unchanged
9.12	Ward Register This lists, in date order, reception of each inpatient into the ward. Information will include date of reception and name of patient.	Destroy	Destroy when reference ceases	Hold in agency pending destruction	Unchanged
9.13	Inpatient Admission and Inpatient Discharge List (electronic or manual) Does not apply to : Admission Register or Admission List where no Admission Register is kept – see Index No. 9.5. Discharge Register or Discharge List where no Discharge Register is kept – see Index No. 9.6.	Destroy	Destroy when reference ceases	Hold in agency pending destruction	Unchanged
9.13.1	Outpatient List, Outpatient Attendance List, Appointment Book or Sheets	Destroy	Destroy when reference ceases	Hold in agency pending destruction	Unchanged
9.13.2	Death List Does not apply to Death Register – see Index No. 9.9.	Destroy	Destroy when reference ceases	Hold in agency pending destruction	Unchanged
9.13.3	Operation or Theatre List or Schedule Does not apply to Operation or Theatre Register – see Index No. 9.10.	Destroy	Destroy when reference ceases	Hold in agency pending destruction	Unchanged

* **Important:** An exception applies to Aboriginal patient records (refer to Section 1, [Parts 3.6](#) and [3.9](#)).

Index No.	Class of Record	Disposal Action	Sentence*	Custody	Review Status
9.14	<p>Bed Return or Daily Inpatient Census</p> <p>This records the number of inpatients present in the ward at the census time and lists any inpatients who have been admitted or transferred in since the previous census and any patients who have been discharged, transferred out or deceased since the previous census time.</p>	Destroy	Destroy 7 years after date of census record, or when audit requirements have been satisfied	Hold in agency pending destruction	Unchanged
9.15	<p>Medical Certificate Issue Book</p> <p>This book contains the medical certificate issued by clinical staff, with the original going to the patient and the duplicate staying in the book.</p> <p>The booklet is a duplicate system with the original being given to the patient for their employee, education facility or Centrelink and the duplicate stays in the booklet.</p>	Destroy	Destroy 7 years after the last certificate in the booklet is issued	Hold in agency pending destruction	Addition
9.16	<p>Paper Records Reproduced as Digitised Records</p> <p>Refers to the original paper records identified in Index No.9.1 to 9.15 that have been successfully digitised in accordance with the Digitisation Policy and Toolkit.</p> <p>For information on the digitisation of patient records refer to Section 1, Part 3.10.1.</p>	Destroy	<p>Reproduced as Digitised Records</p> <p>Destroy source records after reproducing in accordance with Section 1, Part 3.10.1, at least 6 months following digitisation</p>	Hold in agency pending destruction	Addition

* **Important:** An exception applies to Aboriginal patient records (refer to Section 1, [Parts 3.6](#) and [3.9](#)).

10 Summarised and ephemeral documentation

This part covers disposal of ephemeral material of a facilitative nature comprising detailed and frequent observations which are subsequently written in full or summary form in the patient record. The transcribed, summarised or edited record is sentenced according to the appropriate class of record (e.g. summary of patient observations filed in the individual patient record is sentenced according to Index No. 1.1). The destruction of these records is authorised as a normal administrative practice and it is not necessary for details of destruction to be entered into a Record Destruction Register (Refer to Appendix 3 - Record Destruction Register).

Index No.	Class of Record	Disposal Action	Sentence*	Custody	Review Status
10.1	<p>Observations</p> <p>Includes:</p> <ul style="list-style-type: none"> • Daily fluid balance record • Frequent observations • Intensive care observations • Respiratory record. <p>Also includes the monitor strips remaining after editing and mounting or summarising in the patient record for the following:</p> <ul style="list-style-type: none"> • electrocardiogram (ECG) • electroencephalogram (EEG) • electromyogram (EMG) • cardiocogram (CTG) <p>(edited and mounted or summarised records are sentenced according to Index No. 1.1, 1.2, 1.3, 2.1, 2.2 or 3.1).</p>	Destroy	Destroy when information is transcribed, summarised or edited	Hold in agency pending destruction	Unchanged
10.2	<p>Nursing Care Plans</p> <p>Applies to plans which are constantly revised and here revisions obliterate previous entries.</p>	Destroy	Destroy when reference ceases	Hold in agency pending destruction	Unchanged

* **Important:** An exception applies to Aboriginal patient records (refer to Section 1, [Parts 3.6](#) and [3.9](#)).

11 Pathology, laboratory records and diagnostic material

Sentences for Index No. 11.2 and 11.4 – 11.10 are those specified in the National Pathology Accreditation Advisory Council's (NPAAC) [Requirements for the Retention of Laboratory Records and Diagnostic Material \(Sixth Edition 2013\)](#). These guidelines should be consulted for further details or clarification. All reports and registers in this part may exist as a paper-based record, or be held electronically within the laboratory information management system, called Ultra.

Index No.	Class of Record	Disposal Action	Sentence*	Custody	Review Status
11.1	<p>Specimen Registers</p> <p>Refers to registers which record specimens collected or received.</p> <p>Information will include specimen number or other identification, laboratory procedure number or other identification, patient identification, doctor's name, date specimen was collected, date specimen was received, date specimen was examined and by whom, and condition of specimen if unsatisfactory.</p> <p>Specimen registers are used to locate reports, samples, blocks, slides, films, cultures, swabs and other material examined.</p>				

* **Important:** An exception applies to Aboriginal patient records (refer to Section 1, [Parts 3.6](#) and [3.9](#)).

Index No.	Class of Record	Disposal Action	Sentence*	Custody	Review Status
11.1.1	<p>Register of Specimens Collected or Received</p> <p>Refers to registers (electronic or manual) which are used to record all types of specimens. For example, where all types of specimens from Index No. 11.2 – 11.9 are recorded in the same register.</p> <p><i>Used to locate reports, samples, block slides, films, cultures, swabs and other material examined.</i></p>	Destroy	Destroy 28 years after date of examination	Hold in agency pending destruction	Unchanged
11.2	<p>Autopsy/Post Mortem Records</p> <p><i>For further details and/or clarification refer to the NPAAC guidelines.</i></p>				
11.2.1	<p>Autopsy or Post Mortem Reports: Originals</p> <p>The original diagnostic report is filed in the individual patient record and sentenced accordingly.</p>	Destroy	Sentence according to Index No. 1.2 or 2.2	Hold in agency pending destruction	Unchanged
11.2.2	<p>Autopsy or Post Mortem Reports: Duplicates</p> <p>Note</p> <p>1. Forensic and medico-legal autopsy reports must be retained longer - 20 years after date of autopsy.</p>	Destroy	<p>Destroy 10 years after date of autopsy</p> <p>For forensic and medico-legal autopsy, destroy 20 years after date of autopsy</p>	Hold in agency pending destruction	Unchanged

* **Important:** An exception applies to Aboriginal patient records (refer to Section 1, [Parts 3.6](#) and [3.9](#)).

Index No.	Class of Record	Disposal Action	Sentence*	Custody	Review Status
11.2.3	<p>Blocks and Slides: Samples</p> <p>Note</p> <p>1. Forensic and medico-legal autopsy samples must be retained longer - 20 years after date of autopsy.</p>	Destroy	<p>Destroy 10 years after date of autopsy</p> <p><i>For forensic and medico-legal autopsy, destroy 20 years after date of autopsy.</i></p>	Hold in agency pending destruction	Unchanged
11.2.4	<p>Unblocked Tissue (Autopsy)</p> <p>Relates to unblocked tissue from specimens retained at autopsy or post mortem.</p> <p>Note</p> <p>1. Limitations relating to specimen retention may be agreed upon with the deceased's next-of-kin (or family) under the <i>Coroners Act 1996</i> for coronial (forensic and medico-legal) autopsies, and the <i>Human Tissue and Transplant Act 1982</i> for non-coronial autopsies.</p>	Destroy	Destroy 3 months after date of autopsy unless a limitation is imposed (such as the need to reunite retained specimens with the body before a funeral has been stipulated by next-of-kin)	Hold in agency pending destruction	Unchanged
11.2.5	<p>Registers (electronic or manual)</p> <p>Used to locate the reports, blocks and slides in Index No. 11.2.2 and 11.2.4.</p>	Destroy	Destroy 20 years after date of autopsy	Hold in agency pending destruction	Unchanged

* **Important:** An exception applies to Aboriginal patient records (refer to Section 1, [Parts 3.6](#) and [3.9](#)).

Index No.	Class of Record	Disposal Action	Sentence*	Custody	Review Status
11.3	Blood Alcohol Records				
11.3.1	Documents concerning taking of Blood Samples	Destroy	Destroy 3 years after date of taking blood	Hold in agency pending destruction	Unchanged
11.3.2	Register of Blood Samples (electronic or manual) Contains the serial number of the container of blood sample, date and time blood sample was taken and name of the person from whom the sample was taken (or where the name of person is not known, sufficient information to enable the sample to be identified with the person).	Destroy	Destroy 7 years after date of taking blood	Hold in agency pending destruction	Unchanged
11.3.3	Declarations Declarations by a legally qualified medical practitioner as to the grounds for not taking a sample of blood.	Destroy	Destroy 7 years after date of declaration	Hold in agency pending destruction	Unchanged
11.3.4	Results (Positive or Negative)	Destroy	Destroy 3 years after date of taking blood	Hold in agency pending destruction	Unchanged

* **Important:** An exception applies to Aboriginal patient records (refer to Section 1, [Parts 3.6](#) and [3.9](#)).

Index No.	Class of Record	Disposal Action	Sentence*	Custody	Review Status
11.4	<p>Clinical Biochemistry, Immunology and Blood Bank Records</p> <p><i>For further details and/or clarification refer to the NPAAC guidelines.</i></p>				
11.4.1	<p>Diagnostic Reports: Originals</p> <p>The original diagnostic report is filed in the individual patient record. If a cumulative reporting system is used, the most recent copy of the report should be filed in the individual patient record and sentenced accordingly. Previous copies of the cumulative reports are retained in the Pathology Department and sentenced according to Index No. 11.4.2 Duplicate Diagnostic Reports.</p> <p>Note</p> <p>1. Original reports may be held electronically within the laboratory information management system. See Section 1, Part 4.4.3 for further information regarding original records.</p>	Destroy	Sentence according to Index No. 1.1, 1.2, 1.3, 2.1 or 2.2	Hold in agency pending destruction	Unchanged
11.4.2	<p>Diagnostic Reports: Duplicates</p> <p>Including justification for examination of samples (which may be the request form).</p>	Destroy	<p>Destroy 7 years after date of examination (provided the client has attained the age of 18 years)</p> <p>(Where report pertains to genetics sentence according to Index No. 11.8)</p>	Hold in agency pending destruction	Changed

* **Important:** An exception applies to Aboriginal patient records (refer to Section 1, [Parts 3.6](#) and [3.9](#)).

Index No.	Class of Record	Disposal Action	Sentence*	Custody	Review Status
11.4.3	Diagnostic Reports: Duplicates (Blood Bank records only) Including justification for examination of samples (which may be the request form).	Destroy	Destroy 7 years after date of examination (provided the client has attained the age of 18 years) (Where report pertains to genetics sentence according to Index No. 11.8)	Hold in agency pending destruction	Changed
11.4.4	Guthrie Card (specimen) Refers to the card on which the blood sample is collected.	Destroy	Destroy 2 years after date of examination	Hold in agency pending destruction	Unchanged
11.4.5	Guthrie Test Result Refers to the report that provides the Guthrie test result.	Destroy	Destroy 100 years after date of examination	Hold in agency pending destruction	Unchanged
11.4.6	Samples of Serum, Plasma, Other Body Fluids and Other Materials Examined Notes 1. Excludes samples of serum/plasma collected for infectious disease serology refer to Index No. 11.9.6 - Serum/plasma for Infectious Disease Serology. 2. Excludes samples of serum/plasma examined during pregnancy or for syphilis refer to Index No. 11.9.6 - Serum/plasma for Infectious Disease Serology.	Destroy	Destroy specimens 7 days after date of receipt or 2 days after the date of the issued report whichever is longer)	Hold in agency pending destruction	Unchanged

* **Important:** An exception applies to Aboriginal patient records (refer to Section 1, [Parts 3.6](#) and [3.9](#)).

Index No.	Class of Record	Disposal Action	Sentence*	Custody	Review Status
11.4.7	Registers (electronic or manual) Used to locate reports and samples in Index No. 11.4.2 and 11.4.6.	Destroy	Destroy 25 years after date of examination	Hold in agency pending destruction	Unchanged
11.4.8	Registers (electronic or manual) which record details of fresh and pooled blood products. Information will include date of receipt, identification number of donation or batch(s) including quantity in each batch, date of transfusion, identification date of issue to ward, and blood group of the product (if applicable).	Destroy	Destroy 20 years after date of entry into register	Hold in agency pending destruction	Unchanged
11.4.9	Registers (electronic or manual) Used to locate reports and samples in Index No. 11.4.3.	Destroy	Destroy 25 years after date of examination	Hold in agency pending destruction	Unchanged
11.4.10	Statements (Donor) Statement by persons intending to donate blood.	Destroy	Destroy 20 years after action completed	Hold in agency pending destruction	Unchanged

* **Important:** An exception applies to Aboriginal patient records (refer to Section 1, [Parts 3.6](#) and [3.9](#)).

Index No.	Class of Record	Disposal Action	Sentence*	Custody	Review Status
11.5	<p>Cytology Records</p> <p><i>For further details and/or clarification refer to the NPAAC guidelines.</i></p>				
11.5.1	<p>Diagnostic Reports of Slides: Originals</p> <p>The original diagnostic report is filed in the individual patient record.</p> <p>If a cumulative reporting system is used, the most recent copy of the report should be filed in the individual patient record and sentenced accordingly.</p> <p>Previous copies of the cumulative reports are retained in the Pathology Department and sentenced according to Index No. 11.5.2 Duplicate Diagnostic Reports.</p>	Destroy	Sentence according to Index No. 1.1, 1.2, 1.3, 2.1 or 2.2	Hold in agency pending destruction	Unchanged
11.5.2	<p>Diagnostic Reports of Slides: Duplicates</p> <p>Relates to diagnostic reports of slides that may or may not show evidence of malignancy or possible malignancy. Includes justification for examination of slides (which may be request form).</p> <p>Note</p> <p>1. Exfoliative cytology and fine needle aspiration reports must be retained longer - 10 years after date of examination (provided the client has attained the age of 18 years).</p>	Destroy	<p>Destroy 7 years after date of examination (provided the client has attained the age of 18 years)</p> <p>For exfoliative cytology and fine needle aspirations, destroy 10 years after date of examination (provided the client has attained the age of 18 years)</p>	Hold in agency pending destruction	Unchanged

* **Important:** An exception applies to Aboriginal patient records (refer to Section 1, [Parts 3.6](#) and [3.9](#)).

Index No.	Class of Record	Disposal Action	Sentence*	Custody	Review Status
11.5.3	<p>Slides (Cytology)</p> <p>Relates to cytology slides that may or may not show evidence of malignancy or possible malignancy.</p> <p>Note</p> <p>1. Exfoliative cytology and fine needle aspiration slides must be retained longer - 10 years after date of examination (provided the client has attained the age of 18 years).</p>	Destroy	<p>Destroy 7 years after date of examination (provided the client has attained the age of 18 years)</p> <p>For exfoliative cytology and fine needle aspirations, destroy 10 years after date of examination (provided the client has attained the age of 18 years)</p>	Hold in agency pending destruction	Unchanged
11.5.4	<p>Registers (electronic or manual)</p> <p>Used to locate diagnostic reports and slides in Index No. 11.5.2 and 11.5.3.</p>	Destroy	Destroy 28 years after date of examination	Hold in agency pending destruction	Unchanged
11.6	Haematology Records				
11.6.1	<p>Diagnostic Reports of Slides: Originals</p> <p>The original diagnostic report is filed in the individual patient record. If a cumulative reporting system is used, the most recent copy of the report should be filed in the individual patient record and sentenced accordingly.</p> <p>Previous copies of the cumulative reports are retained in the Pathology Department and sentenced according to Index No. 11.6.2 and 11.6.6 Duplicate Diagnostic Reports.</p>	Destroy	Sentence according to Index No. 1.1, 1.2, 1.3, 2.1 or 2.2	Hold in agency pending destruction	Unchanged

* **Important:** An exception applies to Aboriginal patient records (refer to Section 1, [Parts 3.6](#) and [3.9](#)).

Index No.	Class of Record	Disposal Action	Sentence*	Custody	Review Status
11.6.2	Diagnostic Reports of Blood Samples and Films where a significant initial or altered diagnosis is made or where the negative result is significant to patient: Duplicates Including justification for examination (which may be the request form).	Destroy	Destroy 7 years after date of examination (provided the client has attained the age of 18 years) (Where report pertains to genetics sentence according to Index No. 11.8)	Hold in agency pending destruction	Changed
11.6.3	Blood Films Relating to Index No. 11.6.2	Destroy	Destroy 1 year after date of examination	Hold in agency pending destruction	Unchanged
11.6.4	Blood Samples Relating to Index No. 11.6.2	Destroy	Destroy specimens 7 days after date of receipt or 2 days after the date of the issued report (whichever is longer)	Hold in agency pending destruction	Unchanged
11.6.5	Registers (electronic or manual) Used to locate reports, blood samples and films in Index No. 11.6.2, 11.6.3 and 11.6.4.	Destroy	Destroy 25 years after date of examination	Hold in agency pending destruction	Unchanged
11.6.6	Diagnostic Reports of Blood Samples and Films where no significant initial or altered diagnosis is made or where the negative result is not significant to the patient: Duplicates Including justification for examination (which may be the request form).	Destroy	Destroy 7 years after date of examination (provided the client has attained the age of 18 years) (Where report pertains to genetics sentence according to Index No. 11.8)	Hold in agency pending destruction	Changed

* **Important:** An exception applies to Aboriginal patient records (refer to Section 1, [Parts 3.6](#) and [3.9](#)).

Index No.	Class of Record	Disposal Action	Sentence*	Custody	Review Status
11.6.7	Blood Films Relating to Index No. 11.6.6	Destroy	Destroy 1 month after date of examination	Hold in agency pending destruction	Unchanged
11.6.8	Blood Samples Relating to Index No. 11.6.6	Destroy	Destroy specimens 7 days after date of receipt or 2 days after the date of the issued report (whichever is longer)	Hold in agency pending destruction	Unchanged
11.6.9	Registers (electronic or manual) Used to locate reports, blood samples and films in Index No. 11.6.6, 11.6.7 and 11.6.8.	Destroy	Destroy 25 years after date of examination	Hold in agency pending destruction	Unchanged
11.7	Histopathology and Bone Marrow Records <i>For further details and/or clarification refer to the NPAAC guidelines.</i>				
11.7.1	Diagnostic Reports: Originals The original diagnostic report is filed in the individual patient record. If a cumulative reporting system is used, the most recent copy of the report should be filed in the individual patient record and sentenced accordingly. Previous copies of the cumulative reports are retained in the Pathology Department and sentenced according to Index No. 11.7.2 Duplicate Diagnostic Reports.	Destroy	Sentence according to Index No. 1.1, 1.2, 1.3, 2.1 or 2.2	Hold in agency pending destruction	Unchanged

* **Important:** An exception applies to Aboriginal patient records (refer to Section 1, [Parts 3.6](#) and [3.9](#)).

Index No.	Class of Record	Disposal Action	Sentence*	Custody	Review Status
11.7.2	Diagnostic Reports: Duplicates Including justification for examination of samples (which may be the request form).	Destroy	Destroy 10 years after date of examination (provided the client has attained the age of 18 years) (Where report pertains to genetics sentence according to Index No. 11.8)	Hold in agency pending destruction	Changed
11.7.3	Slides and Blocks (Histopathology and bone marrow)	Destroy	Destroy 10 years after date of examination (provided the client has attained the age of 18 years)	Hold in agency pending destruction	Unchanged
11.7.4	Unblocked Tissue Note 1. Excludes samples taken for autopsy or post-mortem. Refer to Index No. 11.2.4 - Unblocked Tissue (Autopsy).	Destroy	Destroy 1 month after date of issue of specimen report	Hold in agency pending destruction	Unchanged
11.8	Genetics Records Diagnostic reports containing genetic material	Destroy	The record must be retained for 100 years	Hold in agency pending destruction	Addition
11.9	Microbiology Records <i>For further details and/or clarification refer to the NPAAC guidelines.</i>				
11.9.1	Diagnostic Reports: Originals The original diagnostic report is filed in the individual patient record. If a cumulative reporting system is used, the most recent copy of the report should be filed in the individual patient record and sentenced accordingly.	Destroy	Sentence according to Index No. 1.1, 1.2, 1.3, 2.1 or 2.2	Hold in agency pending destruction	Unchanged

* **Important:** An exception applies to Aboriginal patient records (refer to Section 1, [Parts 3.6](#) and [3.9](#)).

Index No.	Class of Record	Disposal Action	Sentence*	Custody	Review Status
	<p>Diagnostic Reports: Originals Continued</p> <p>Previous copies of the cumulative reports are retained in the Pathology Department and sentenced according to Index No. 11.9.2 Duplicate Diagnostic Reports.</p>				
11.9.2	<p>Diagnostic Reports: Duplicates</p> <p>Including justification for examination of samples (which may be the request form).</p>	Destroy	Destroy 7 years after date of examination (provided the client has attained the age of 18 years)	Hold in agency pending destruction	Unchanged
11.9.3	Stained Slides	Destroy	<p>Destroy:</p> <ul style="list-style-type: none"> • Wet preparations immediately after examination • Immunofluorescence slides 7 days after examination • Gram stains 2 weeks after examination • Ziehl-Neelsen stains 6 weeks after examination • Other stained slides 2 weeks after examination 	Hold in agency pending destruction	Unchanged

* **Important:** An exception applies to Aboriginal patient records (refer to Section 1, [Parts 3.6](#) and [3.9](#)).

Index No.	Class of Record	Disposal Action	Sentence*	Custody	Review Status
11.9.4	Isolates (of organisms)	Destroy	Destroy: <ul style="list-style-type: none"> Clinically significant isolates 5 days after identification Not clinically significant isolates after completion of testing 	Hold in agency pending destruction	Unchanged
11.9.5	Swabs, Specimens and Other Material Examined Note 1. Excludes samples of serum/plasma for collected for infectious disease serology refer to Index No. 11.9.6 - Serum/plasma for Infectious Disease Serology.	Destroy	Destroy specimens 7 days after date of receipt or 2 days after the date of the issued report (whichever is longer)	Hold in agency pending destruction	Unchanged
11.9.6	Serum/plasma for Infectious Disease Serology Includes serum/plasma examined during pregnancy or for syphilis. Notes 1. Antenatal sera must be retained longer – 12 months after date of examination. 2. Syphilis (reactive) must be retained longer – 12 months after date of examination.	Destroy	Destroy all sera (unless specified below) 4 months after date of examination For antenatal sera, destroy 12 months after date of examination For syphilis (reactive), destroy 12 months after date of examination	Hold in agency pending destruction	Unchanged

* **Important:** An exception applies to Aboriginal patient records (refer to Section 1, [Parts 3.6](#) and [3.9](#)).

Index No.	Class of Record	Disposal Action	Sentence*	Custody	Review Status
11.9.7	Registers (electronic or manual) Used to locate reports, cultures, stained slides, swabs, specimens and other material described in 11.9.2 – 11.9.6.	Destroy	Destroy 25 years after date of examination	Hold in agency pending destruction	Unchanged
11.10	Request Forms for Pathology <i>For further details and/or clarification refer to the NPAAC guidelines.</i>				
11.10.1	Request Forms Where justification for examination has not been written into diagnostic report.	Destroy	Sentence according to appropriate diagnostic category (Index No 11.4.2, 11.5.2, 11.5.5, 11.6.2, 11.6.6, 11.7.2, 11.8 or 11.9.2)	Hold in agency pending destruction	Unchanged
11.10.2	Request Forms: Information Duplicated in Diagnostic Report Where justification for examination has been written into diagnostic report.	Destroy	Destroy when reference ceases	Hold in agency pending destruction	Unchanged
11.11	Paper Records Reproduced as Digitised Records Refers to diagnostic reports and other pathology paper records identified in Index No. 11.1 – 11.10.2 that have been successfully digitised in accordance with the Digitisation Policy and Toolkit. For information about the digitisation of patient records refer to Section 1, Part 3.10.1 .	Destroy	Reproduced as Digitised Records Destroy source records after reproducing in accordance with Section 1, Part 3.10.1 , at least 6 months following digitisation	Hold in agency pending destruction	Updated

* **Important:** An exception applies to Aboriginal patient records (refer to Section 1, [Parts 3.6](#) and [3.9](#)).

Index No.	Class of Record	Disposal Action	Sentence*	Custody	Review Status
11.12	Microform and Related Affidavits Refers to pathology laboratory records and diagnostic material on microfilm, microfiche or other microforms and affidavits on paper or in microform.				
11.12.1	Microform Master Copies	Destroy	Sentence according to appropriate sentence for paper records in Index No. 11.1 – 11.10.2	Hold in agency pending destruction	Unchanged
11.12.2	Superseded Master Copies	Destroy	Destroy when superseded	Hold in agency pending destruction	Unchanged
11.12.3	Affidavits Relating to Microfilming Refers to paper and microform copies.	Destroy	Destroy at same time as master microform to which they relate	Hold in agency pending destruction	Unchanged

* **Important:** An exception applies to Aboriginal patient records (refer to Section 1, [Parts 3.6](#) and [3.9](#)).

12 Drug records

Drug or medication charts comprising the medication order(s) written by medical staff and record of administration written by nursing and/or medical staff should be filed in the individual patient record and sentenced according to Index No. 1.1, 1.2, 1.3, 2.1 or 2.2. The retention of the following records for Schedule 8 and Schedule 4 drugs is required under the *Poisons Act 1964* and the *Poisons Regulations 1965 (WA)*.

Index No.	Class of Record	Disposal Action	Sentence*	Custody	Review Status
12.1	Drug of Addiction Records Order book Orders to supply issued by a medical practitioner or dentist Drug of addiction requisition book Authorisation from a medical practitioner or dentist to administer drug of addiction Drug of addiction administration book Drug of addiction register Drug of addiction stock check sheets Prescription <i>Poisons Regulations 1965 reg 47.</i>	Destroy	Destroy 7 years after last date on record	Hold in agency pending destruction	Unchanged
12.2	Prescription Only Records Order book Orders to supply issued by a medical practitioner or dentist.	Destroy	Destroy 2 years after last date on record	Hold in agency pending destruction	Unchanged

* **Important:** An exception applies to Aboriginal patient records (refer to Section 1, [Parts 3.6](#) and [3.9](#)).

Index No.	Class of Record	Disposal Action	Sentence*	Custody	Review Status
	Prescription Only Records Continued Requisition book Authorisation from a medical practitioner or dentist to administer a prescription drug Administration of prescription drug records Emergency supply records Prescriptions Invoices, orders or other documentation <i>Poisons Regulations 1965 reg 41B.</i>				
12.3	Paper Records Reproduced as Digitised Records Refers to pharmacy paper records identified in Index No. 12.1 – 12.2 that have been successfully digitised in accordance with the Digitisation Policy and Toolkit documents. For information on the digitisation of patient records refer to Section 1, Part 3.10.1 .	Destroy	Reproduced as Digitised Records Destroy source records after reproducing in accordance with Section 1, Part 3.10.1 , at least 6 months following digitisation	Hold in agency pending destruction	Updated
12.4	Microform and Related Affidavits Refers to pathology laboratory records and diagnostic material on microfilm, microfiche or other microforms and affidavits on paper or in microform.				
12.4.1	Microform Master Copies	Destroy	Sentence according to appropriate sentence for paper records in Index No. 12.1 – 12.2	Hold in agency pending destruction	Unchanged

* **Important:** An exception applies to Aboriginal patient records (refer to Section 1, [Parts 3.6](#) and [3.9](#)).

Index No.	Class of Record	Disposal Action	Sentence*	Custody	Review Status
12.4.2	Superseded Master Copies	Destroy	Destroy when superseded	Hold in agency pending destruction	Unchanged
12.4.3	Affidavits Relating to Microfilming Refers to paper and microform copies.	Destroy	Destroy at same time as master microform to which they relate	Hold in agency pending destruction	Unchanged

* **Important:** An exception applies to Aboriginal patient records (refer to Section 1, [Parts 3.6](#) and [3.9](#)).

13 Imaging records

This part includes Diagnostic Radiology, Nuclear Medicine, Ultrasound, Computed Tomography and Magnetic Resonance Imaging and Clinical Photography records.

Index No.	Class of Record	Disposal Action	Sentence*	Custody	Review Status
13.1	Diagnostic Reports Refers to Diagnostic Radiology, Nuclear Medicine, Ultrasound, Computed Tomography (CT), Magnetic Resonance Imaging (MRI).				
13.1.1	Diagnostic Reports: Originals Original imaging service report should be filed in the individual patient record.	Destroy	Sentence according to Index No. 1.1, 1.2, 1.3, 2.1 or 2.2	Hold in agency pending destruction	Unchanged
13.1.2	Diagnostic Reports: Duplicates Including justification for examination (which may be the request form).	Destroy	Destroy 7 years after date of report	Hold in agency pending destruction	Unchanged
13.2	Film and Similar Visual Materials Radiographic films or diagnostically equivalent images. These should be retained in the Radiology Department.	Destroy	Destroy (re-cycle) 7 years after date of last attendance for diagnostic imaging	Hold in agency pending destruction	Unchanged

* **Important:** An exception applies to Aboriginal patient records (refer to Section 1, [Parts 3.6](#) and [3.9](#)).

Index No.	Class of Record	Disposal Action	Sentence*	Custody	Review Status
13.3	Registers (File Index) Registers (electronic and manual) used to locate reports, film and similar visual materials for Diagnostic Reports (originals and duplicates) and film and other visual materials.	Destroy	Destroy when all film and visual materials registered have been destroyed	Hold in agency pending destruction	Unchanged
13.4	Request Forms				
13.4.1	Request forms where justification for examination has not been written into another record.	Destroy	Destroy 7 years after date of report (provided the patient has attained the age of 25 years)	Hold in agency pending destruction	Unchanged
13.4.2	Request forms where the justification for examination is incorporated into another record.	Destroy	Destroy when reference ceases	Hold in agency pending destruction	Unchanged
13.5	Paper Records Reproduced as Digitised Records Refers to imaging paper records identified in Index No. 13.1 – 13.4.2 that have been successfully digitised in accordance with the Digitisation Policy and Toolkit documents. For information on the digitisation of patient records refer to Section 1, Part 3.10.1	Destroy	Reproduced as Digitised Records Destroy source records after reproducing in accordance with Section 1, Part 3.10.1 , at least 6 months following digitisation	Hold in agency pending destruction	Updated

* **Important:** An exception applies to Aboriginal patient records (refer to Section 1, [Parts 3.6](#) and [3.9](#)).

Index No.	Class of Record	Disposal Action	Sentence*	Custody	Review Status
13.5.1	Diagnostic Reports: Originals	Destroy	Sentence according to Index No. 1.5 or 2.4	Hold in agency pending destruction	Unchanged
13.5.2	Diagnostic Reports: Duplicates	Destroy	Destroy when reference ceases	Hold in agency pending destruction	Unchanged
13.6	Microform and Related Affidavits Refers to imaging records on microfilm, microfiche or other microforms and affidavits on paper or in microform.				
13.6.1	Microform Master Copies	Destroy	Sentence according to appropriate sentence for paper records in Index No. 13.1.1 – 13.4.2	Hold in agency pending destruction	Unchanged
13.6.2	Superseded Master Copies	Destroy	Destroy when superseded	Hold in agency pending destruction	Unchanged
13.6.3	Affidavits Refers to paper and microform copies.	Destroy	Destroy at same time as master microform to which they relate	Hold in agency pending destruction	Unchanged

* **Important:** An exception applies to Aboriginal patient records (refer to Section 1, [Parts 3.6](#) and [3.9](#)).

Index No.	Class of Record	Disposal Action	Sentence*	Custody	Review Status
13.7	Photographs Excludes diagnostic images – see Index No. 13.1 and 13.2.	Destroy	If photograph is filed in the individual patient record, sentence according to Index No. 1.1, 1.2, 1.3, 2.1 or 2.2	Hold in agency pending destruction	Unchanged
13.7.1	Reference and/or Teaching Collections Includes transparencies and prints.	Destroy	Destroy when reference ceases	Hold in agency pending destruction	Unchanged
13.8	Medical Imaging (X-ray) Register Includes information concerning patient attendance and financial reports.	Destroy	Destroy 7 years after date of last attendance	Hold in agency pending destruction	Unchanged

* **Important:** An exception applies to Aboriginal patient records (refer to Section 1, [Parts 3.6](#) and [3.9](#)).

14 Statutory notifications of births and deaths

This part relates to records of statutory notifications of births and deaths held by public health care facilities.

Index No.	Class of Record	Disposal Action	Sentence*	Custody	Review Status
14.1	<p>Statutory Notification of Births and Deaths</p> <p>Births</p> <p>As required under the:</p> <ul style="list-style-type: none"> • <i>Health Act 1911 s 335</i> • <i>Births Deaths and Marriages Registration Act 1998 ss 12, 13</i> <p>The hospital's copy of the Statutory Notification (Notification of Case Attended – MR 15) must be filed in the individual patient record. A copy may also be retained separately.</p> <p>Deaths</p> <p>As required under the:</p> <ul style="list-style-type: none"> • <i>Births Deaths and Marriages Registration Act 1998 s 40</i> • <i>Health Act 1911 ss 276, 284, 335, 336, 336A and 336B</i> • <i>Notification of Stillbirth and Neo-Natal Death Regulations reg 2</i> 				

* **Important:** An exception applies to Aboriginal patient records (refer to Section 1, [Parts 3.6](#) and [3.9](#)).

Index No.	Class of Record	Disposal Action	Sentence*	Custody	Review Status
14.1.1	Filed in the individual patient record	Destroy	Sentence according to Index No. 1.1, 1.2, 1.3, 2.1 or 2.2	Hold in agency pending destruction	Unchanged
14.1.2	Copy retained separately	Destroy	Destroy 1 year after last date of notification	Hold in agency pending destruction	Unchanged

* **Important:** An exception applies to Aboriginal patient records (refer to Section 1, [Parts 3.6](#) and [3.9](#)).

15 Statutory health reports

This part relates to records of statutory notifications of infectious disease, venereal disease (including syphilis in a non-infectious stage), cancer, lead poisoning, adverse events following immunisation, and other notifiable diseases held by public health care facilities.

Index No.	Class of Record	Disposal Action	Sentence*	Custody	Review Status
15.1	<p>Statutory Health Reports</p> <p>Refers to copies or butts of documents fulfilling obligations under the:</p> <ul style="list-style-type: none"> • <i>Drugs of Addiction Notification Regulations 1980 reg 4</i> • <i>Health Act 1911 ss 276, 287, 292 and 300</i> • <i>Health Legislation Administration Act 1984</i> • <i>Health (Cervical Cytology Register) Regulations 1991 reg 9</i> • <i>Health (Notification of Adverse Event after Immunisation) Regulations 1995 reg 4</i> • <i>Health (Notification of Cancer) Regulations 1981 regs 5 and 6</i> • <i>Health (Notification of Lead Poisoning) Regulations 1985 reg 5</i> • <i>Health (Venereal Diseases) Regulations 1973 reg 2C</i> • <i>Mental Health Act 1996 ss 115, 120, 124, 201</i> • <i>Mental Health Regulations 1997 regs 5, 17</i> <p>The hospital copy of the health report may be filed in the individual patient record or retained in separate agency files.</p>				

* **Important:** An exception applies to Aboriginal patient records (refer to Section 1, [Parts 3.6](#) and [3.9](#)).

Index No.	Class of Record	Disposal Action	Sentence*	Custody	Review Status
15.1.1	Filed in the individual patient record	Destroy	Sentence according to Index No. 1.1, 1.2, 1.3, 2.1 or 2.2	Hold in agency pending destruction	Unchanged
15.1.2	Filed in Agency notification files	Destroy	Destroy 7 years after date of notification, provided there is no reasonable expectation of legal implication at time of disposal (refer to Section 1, Part 4.2)	Hold in agency pending destruction	Unchanged
15.1.3	Notification database A register (electronic or manual) used to list statutory health notifications.	Paper Archive	Restricted access archive	Transfer to SRO 25 years after reference ceases	Unchanged
		Electronic Archive within Agency	Restricted access archive	Hold within agency and preserve in accordance with SRC Standard 8 and the Department's policies (refer to Section 1, Part 3.1.1)	

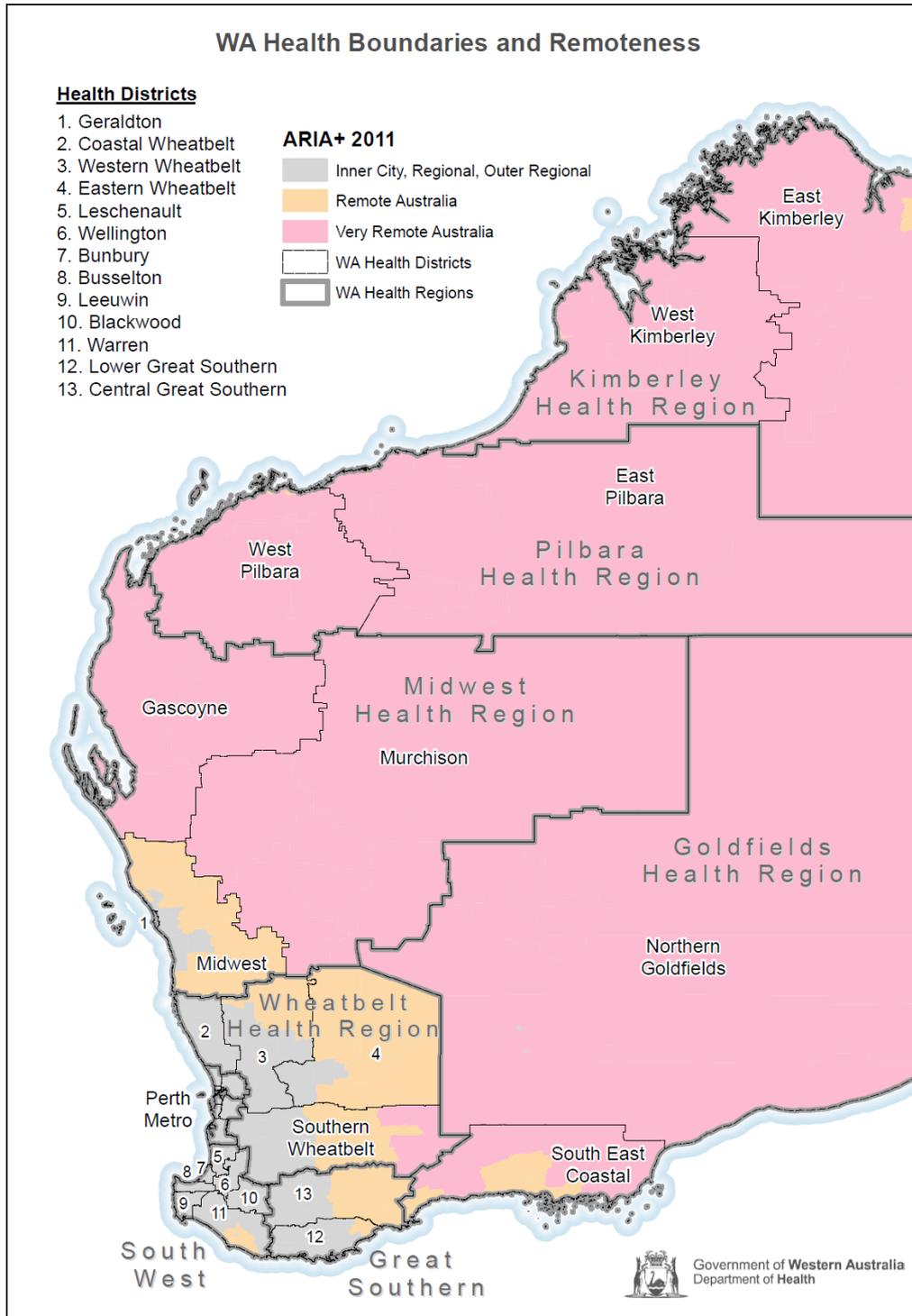
* **Important:** An exception applies to Aboriginal patient records (refer to Section 1, [Parts 3.6](#) and [3.9](#)).

Index No.	Class of Record	Disposal Action	Sentence*	Custody	Review Status
15.2	Infectious Disease Registry Documents Includes: <ul style="list-style-type: none"> • Infectious Disease Notification forms • HIV Notification form • Acquired immune deficiency syndrome (AIDS) Notification form • Adverse Immunisation Events form. 				
15.2.1	Agency notification files	Destroy	Destroy 7 years after date of notification, provided there is no reasonable expectation of legal implication at time of disposal (refer to Section 1, Part 4.2)	Hold in agency pending destruction	Unchanged
15.2.2	State-wide Infectious Disease Notification Database A register (electronic or manual) used to list infectious disease notifications.	Paper Archive Electronic Archive within Agency	Restricted access archive Restricted access archive	Transfer to SRO 25 years after reference ceases Hold within agency and preserve in accordance with SRC Standard 8 and the Department's policies (refer to Section 1, Part 3.1.1)	Unchanged

* **Important:** An exception applies to Aboriginal patient records (refer to Section 1, [Parts 3.6](#) and [3.9](#)).

Section 3 Appendices

Appendix 1 – WA Health districts and remoteness

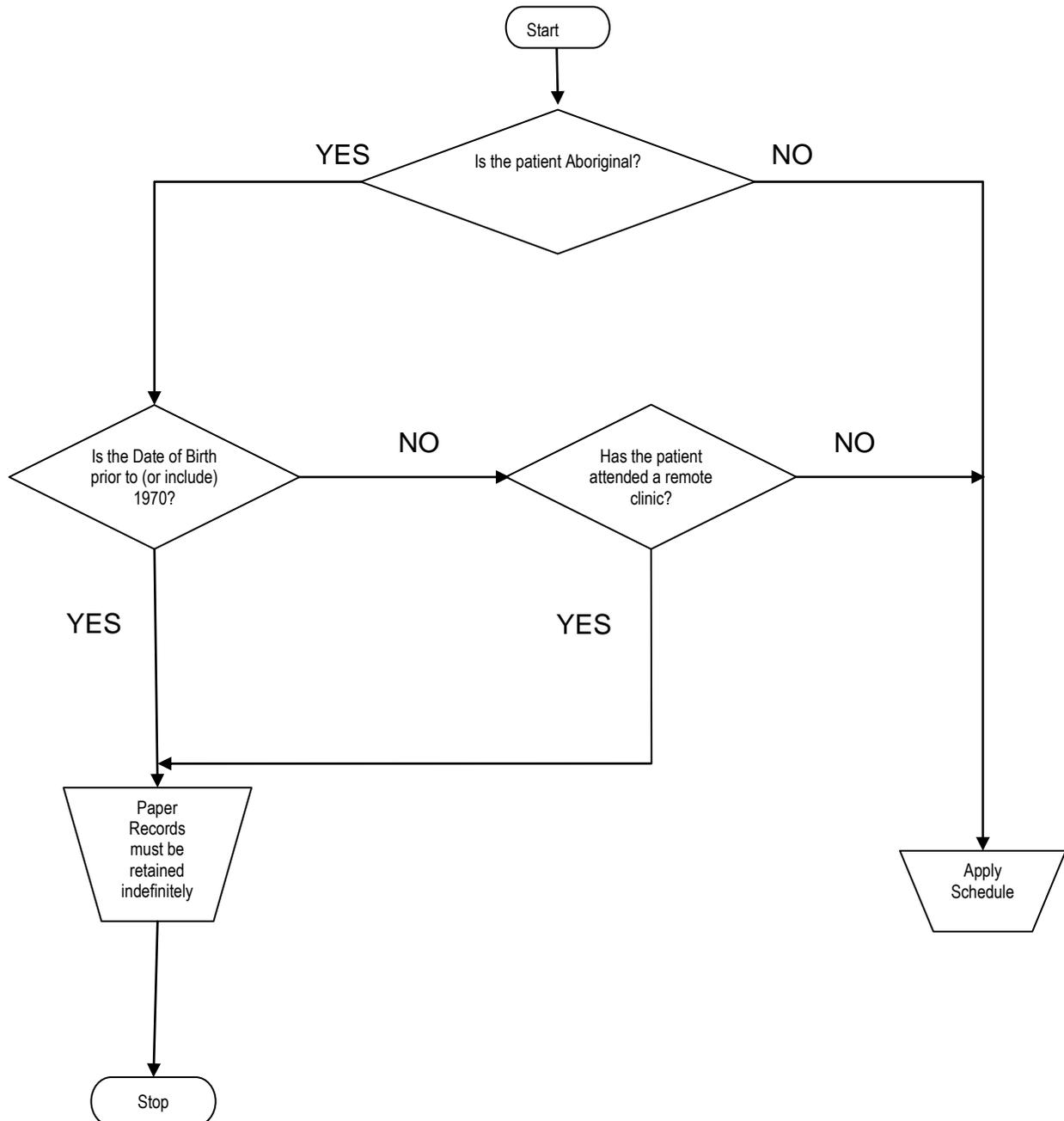


Source: Geographic Information Systems Group, Epidemiology Branch, Department of Health, August 2014.

Appendix 2 – Decision flow charts for records

Aboriginal Records*

Aboriginal patient records must be retained indefinitely for patients with a date of birth prior to and including 1970. Additionally, all remote clinic patient records from the Kimberley or Pilbara Health Regions must be retained indefinitely. This flowchart applies to all records listed in the Schedule except Case Management Program records due to their complex nature and sensitivity (refer to Section 1, Part 3.9).

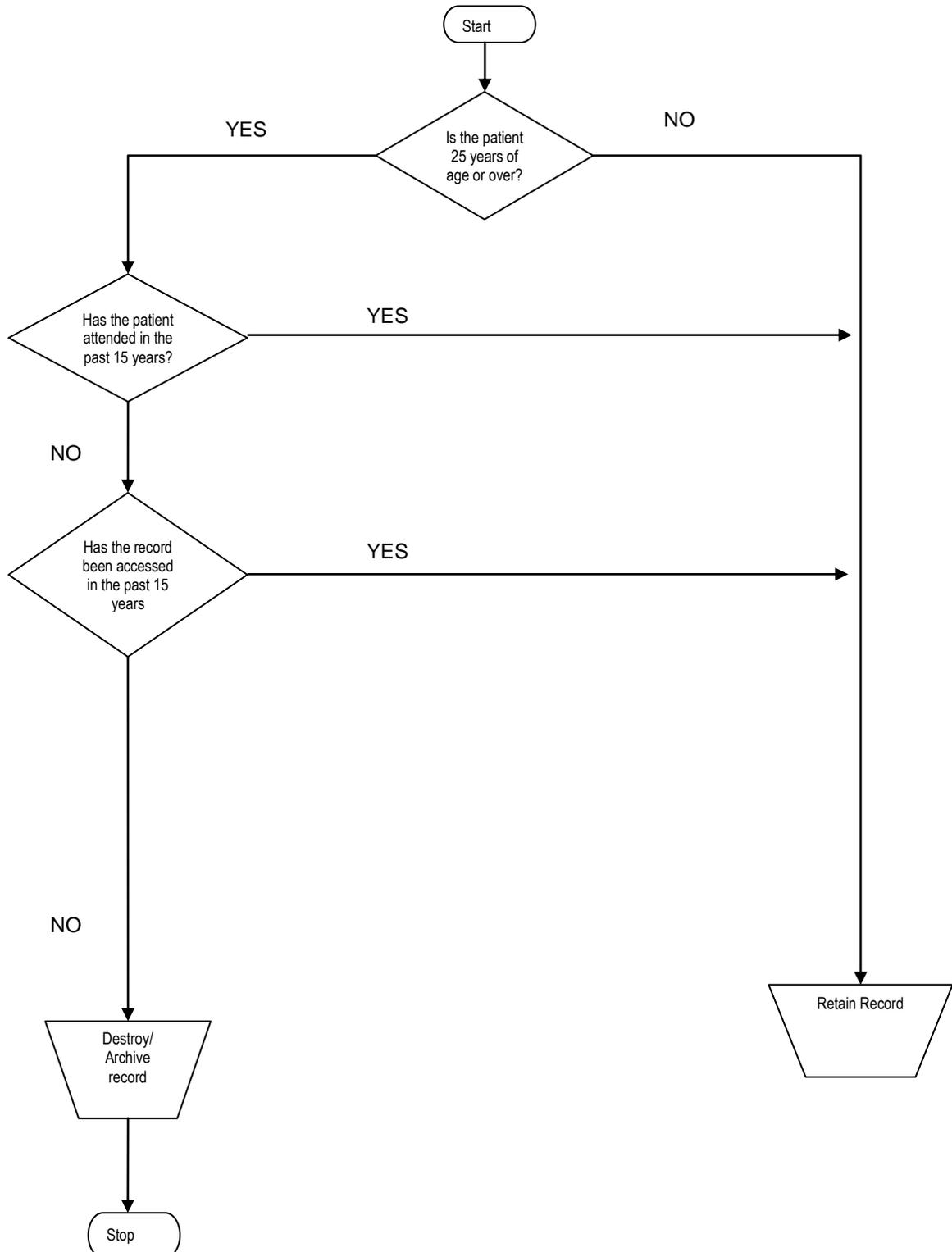


* **Note:** When applying the Schedule refer to Section 1, Parts 3.10.1 and 4.4.2 to assess the suitability for the digitisation and disposal of the original paper record (i.e. source record).

ACUTE HOSPITALS

Acute Individual Patient Records*

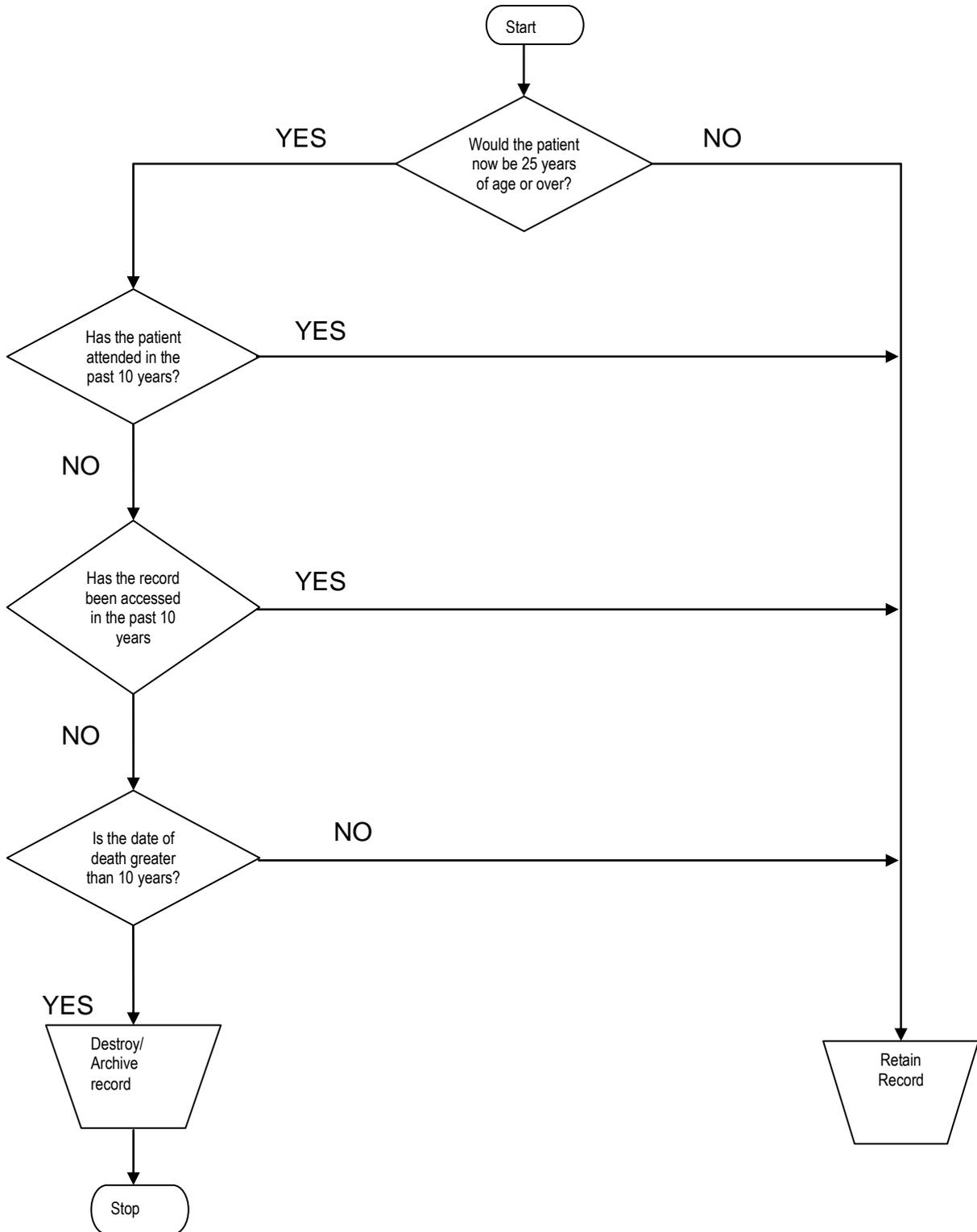
This includes Discharged Patients/ Outpatient and Emergency Medicine



* **Note:** When applying the Schedule refer to Section 1, Parts 3.10.1 and 4.4.2 to assess the suitability for the digitisation and disposal of the original paper record (i.e. source record) 6 months after digitisation.

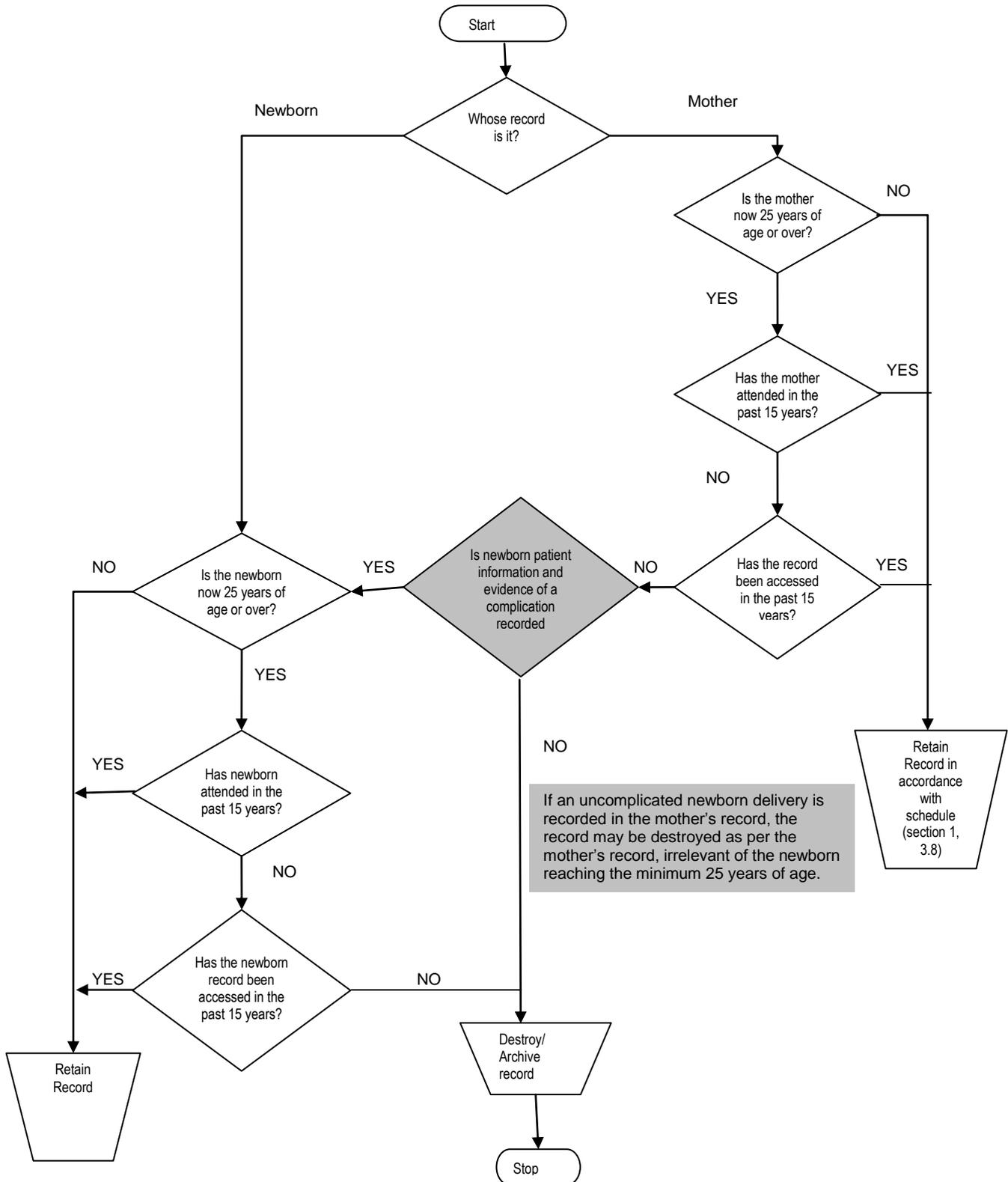
ACUTE HOSPITALS

Acute Deceased Patient Records*



* **Note:** When applying the Schedule refer to Section 1, Parts 3.10.1 and 4.4.2 to assess the suitability for the digitisation and disposal of the original paper record (i.e. source record) 6 months after digitisation.

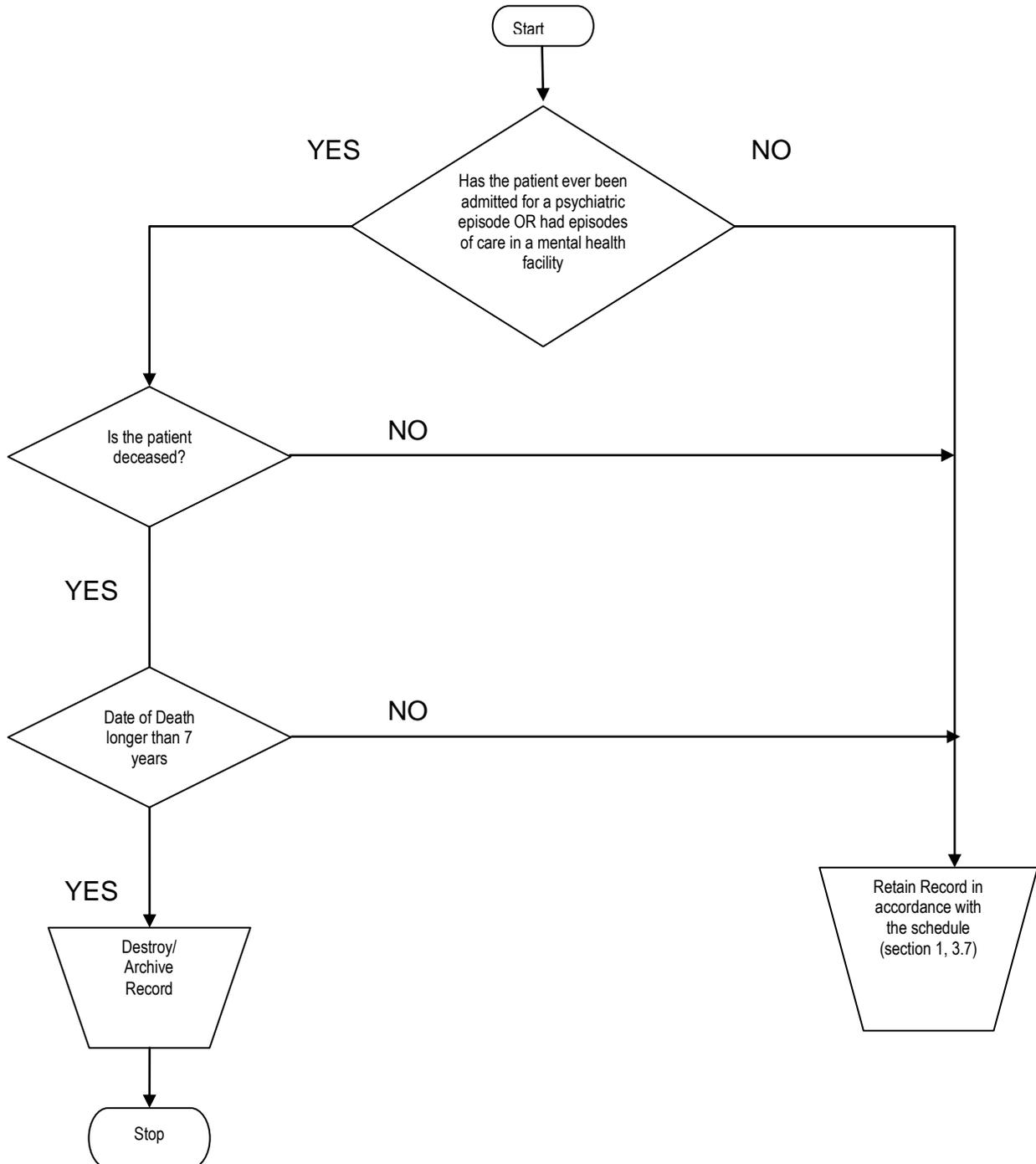
ACUTE HOSPITALS
Obstetric (and Newborn) Patient Records*
This includes mother and newborn records together



* **Note:** When applying the Schedule refer to Section 1, Parts 3.10.1 and 4.4.2 to assess the suitability for the digitisation and disposal of the original paper record (i.e. source record) 6 months after digitisation.

ACUTE HOSPITALS Psychiatric Records*

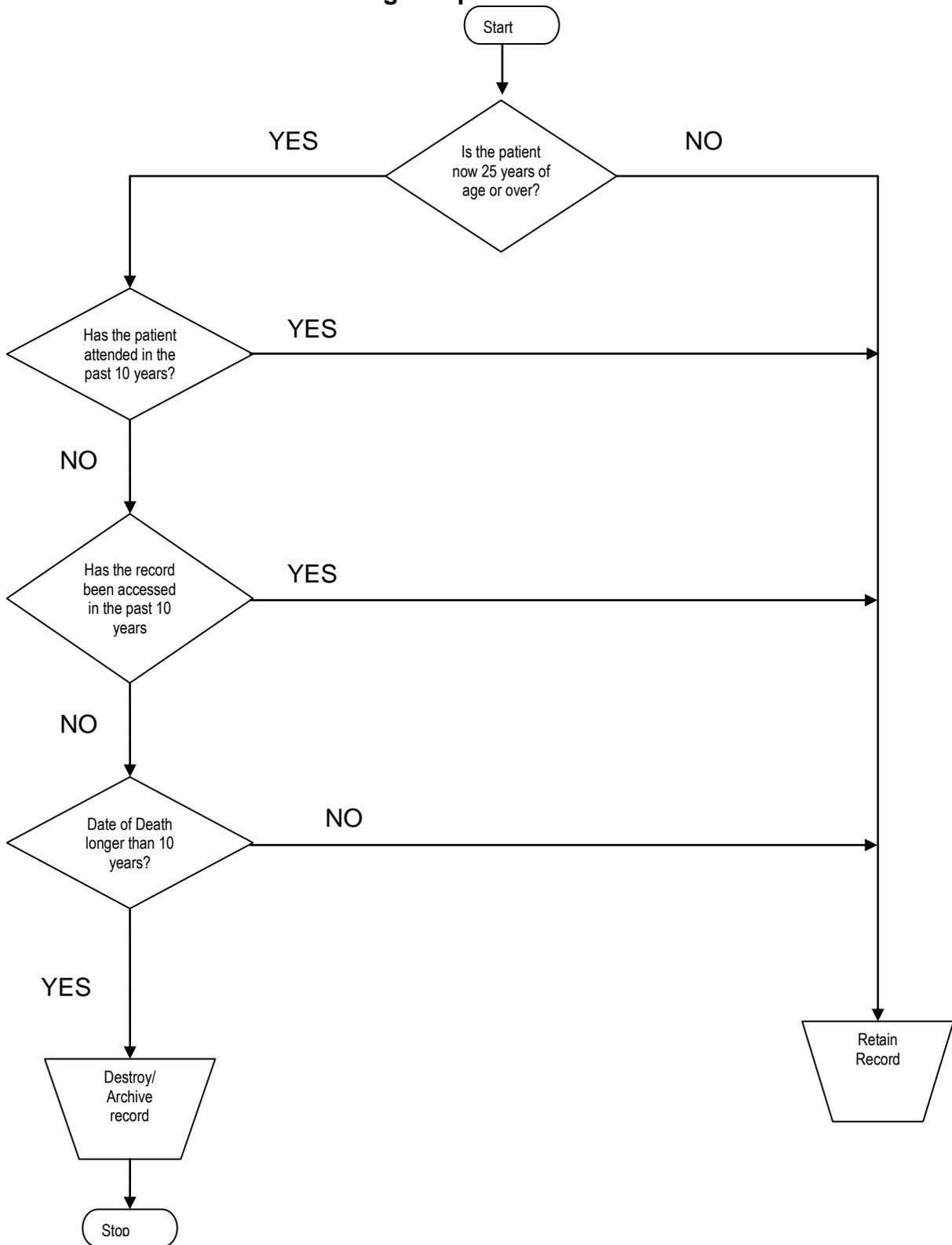
The retention periods specified in the Schedule do not apply to psychiatric patient records. All psychiatric patient records are to be retained for seven years following death



* **Note:** When applying the Schedule refer to Section 1, Parts 3.10.1 and 4.4.2 to assess the suitability for the digitisation and disposal of the original paper record (i.e. source record) 6 months after digitisation.

EXTENDED CARE FACILITIES

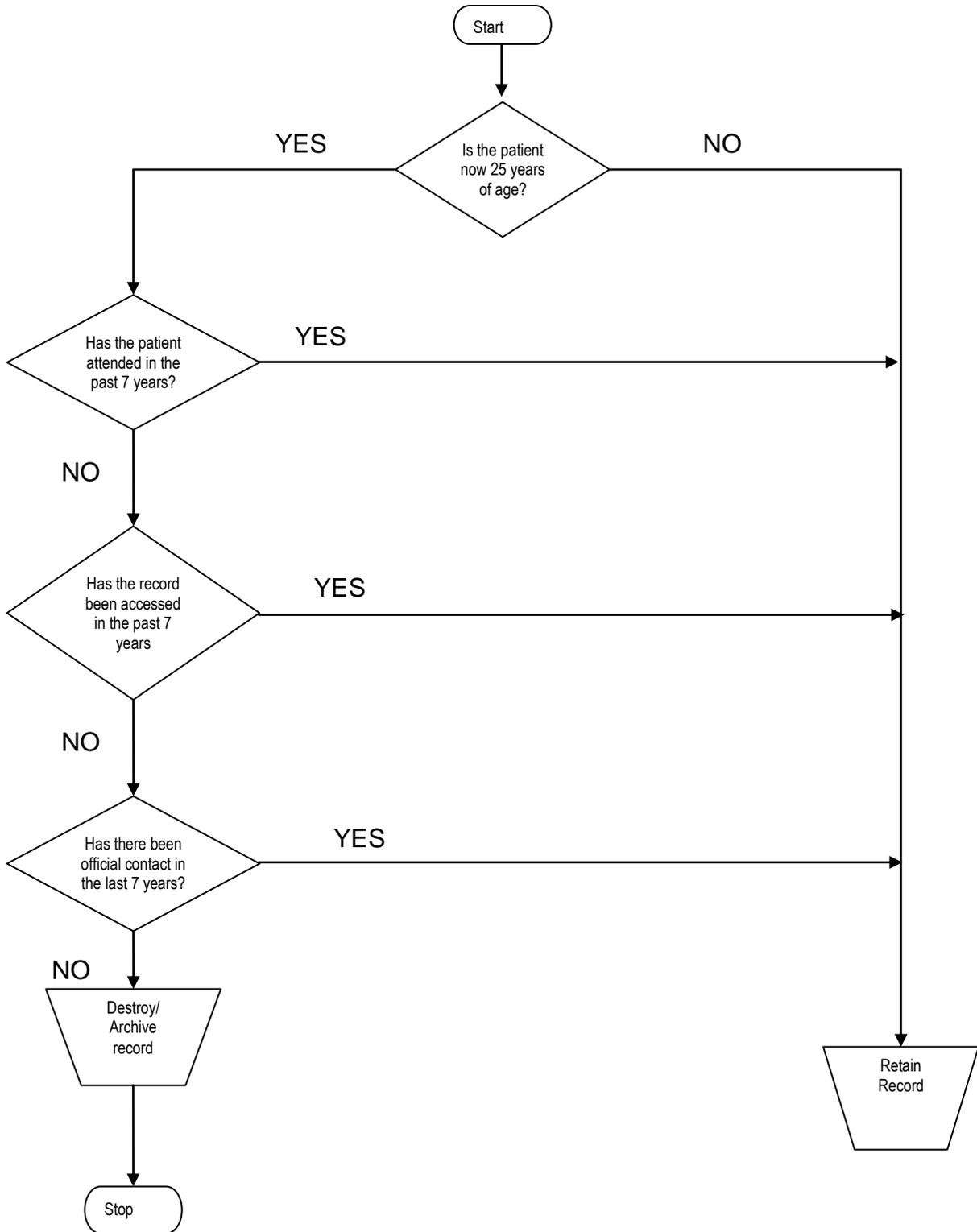
Extended Care Facility Inpatient* Includes Discharged Inpatient and Deceased



* **Note:** When applying the Schedule refer to Section 1, Parts 3.10.1 and 4.4.2 to assess the suitability for the digitisation and disposal of the original paper record (i.e. source record) 6 months after digitisation.

EXTENDED CARE FACILITIES

Non Inpatient Extended Care Facility Patient* Day Hospitals/ Day Centres or Domiciliary Care Services



* **Note:** When applying the Schedule refer to Section 1, Parts 3.10.1 and 4.4.2 to assess the suitability for the digitisation and disposal of the original paper record (i.e. source record) 6 months after digitisation.

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