College of Occupational Therapists of Ontario
Ordre des ergothérapeutes de l'Ontario

Record Keeping Checklist

OTs are accountable for meeting practice standards. This Checklist is intended to support OTs in meeting the Standards for Record Keeping by providing a quick reference with a focus on administration. Not all requirements are included in the Checklist. This Checklist should be used in conjunction with the Standards for Record Keeping to ensure performance expectations are met.

Record Management

I am the:

☐ Health Information Custodian (HIC) ☐ Agent of the Health Information Custodian

Organization and Administration

Each record is:

☐ Legible and understandable ☐ Dated and systematically organized ☐ Signed with the appropriate designation

Clinical Record Information

Each record includes:

- ☐ Client's full name, address and unique identifier (e.g. date of birth, health record/claim number)
- ☐ Referral source
- ☐ Relevant health and social history
- ☐ Date of each professional encounter with the client
- ☐ Receipt of delegated controlled acts
- ☐ Transfer of care to others
- ☐ Record of occupational therapy assessments and/or results
- ☐ Record of transfer or assignment of care to others
- ☐ Record of occupational therapy interventions
- ☐ Progress notes (if applicable)
- ☐ References to any specific care maps or clinical pathways
- ☐ Defined acronyms and abbreviations
- ☐ Notation of any modifications, errors, revisions and additions
- ☐ All relevant communications regarding the client
- ☐ Discharge information or discontinuation note (if applicable)
- ☐ Client identifiers on **each part** of the record

Privacy and Access

☐ Only information relevant to the OT intervention is collected

☐ Process exists to facilitate client access to his or her personal health information

Confidentiality and Security

Each record is:

☐ Securely stored and managed to prevent unauthorized access

☐ In compliance with legislation, organizational policies and procedures related to the security of records

Consent

Informed consent obtained and documented for:

☐ Assessment ☐ Intervention ☐ Collection, Use and Disclosure of Personal Health Information

☐ Involvement of other care providers

Retention and Destruction

☐ Records are retained for 10 years or age of 18 + 10 years for client's under the age of 18

☐ Records are securely destroyed after retention requirement is met

Financial Records

☐ Client name ☐ Date of service ☐ Service or product provided and associated fees

☐ Date and method of payment

Equipment Records

☐ Record of equipment maintenance activities or maintenance protocol (if applicable)