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Disposal Schedule for Patient and Medical Records

Disposal Authorisation No. DS 20

Department of Health and Human Services

Department of Education
LINC Tasmania

Tasmania
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INTRODUCTION

Archives legislation

The *Archives Act 1983* stipulates that State and local government organisations, must not dispose of **records of any type or format** without the written approval of the State Archivist. Disposal of records involves their destruction, their removal from the custody of their creating Agency, or their transfer to the Tasmanian Archive & Heritage Office.

Schedule elements and arrangement

The administrative functions covered by this schedule are arranged in alphabetical order as function headings. The activities performed under each function are listed in alphabetical order within each function.

- ***Reference***

All function and activity headings and disposal classes are allocated a reference number. These reference numbers are used, in conjunction with the schedule number, to identify records in the Tasmanian Archive & Heritage Office disposal documentation. These numbers can also be used by agencies, in the same way, to indicate disposal authorisation in their records control systems, where the records have been registered in these systems.

- ***Disposal classes***

The groups of records that document, and are derived from, the performance of the functions and activities are listed as disposal classes under each function/activity set.

It should be noted that Disposal Classes have been described in functional terms irrespective of the format or medium in which the records were created.

- ***Status***

All disposal classes have either 'PERMANENT' or 'TEMPORARY' status. Records identified as 'PERMANENT' are those that will be transferred to the Archives Office to be retained as State archives. 'TEMPORARY' records are those that can be destroyed under the authority of this schedule.

- ***Disposal action***

All temporary records identified in this schedule will have a disposal action which specifies the length of time for which the record must be retained before it can be destroyed under this authorisation.

Review of the schedule

It is the responsibility of agencies to monitor administrative, legal or regulatory changes which may result in the need to alter disposal class descriptions or disposal actions for records covered by this schedule. When this occurs, this schedule should not be used to dispose of those records and the State Archivist should be informed of the need to revise the schedule. If necessary, the procedures for the disposal of unscheduled records can be used in the interim. Reviews may also be initiated by the Tasmanian Archive & Heritage Office.

Contacts

Any enquiries relating to this schedule should be directed in writing to the Tasmanian Archive & Heritage Office, 91 Murray Street, Hobart, email gisu@education.tas.gov.au , phone 03 6165 5581

TASMANIAN ARCHIVE & HERITAGE OFFICE

DISPOSAL AUTHORISATION No. *DS 20*

Title: **Disposal Schedule for Patient and Medical Records for Department of Health and Human Services.**

Authorisation:

Under Section 20 (2) (b) of the *Archives Act 1983*, I hereby authorise 'relevant authorities' (as defined in Section 3 of that Act) to manage the disposal of the records described in this schedule in accordance with the procedures specified herein.

Ross Latham
State Archivist

Document Development History
Build Status

Version	Date	Author	Reason	Sections
3.0	24-07-2015	Christine Woods	Template	All
2.0	17-12-2004	TAHO	Amendment	All
1.0	07-03-1995	TAHO	Initial Release	All

Amendments in this Release

Section Title	Section Number	Amendment Summary
All	All	Document imported into new template.

INTERPRETATION

Definitions

Permanent records are those that will be transferred to the Tasmanian Archive & Heritage Office to be retained as State Archives. The *Archives Act 1983* establishes 25 years as the maximum required timeframe for the transfer of permanent records to the Tasmanian Archive & Heritage Office unless an extension of time has been approved by the State Archivist.

Temporary records are those that can be destroyed under the authority of this schedule after a minimum retention period, or once certain requirements have been met.

Coverage

This schedule covers Patient and Medical records.

This schedule **does not cover pre-1960 records**. The disposal of those records should be managed according to the procedures for unscheduled records.

The *Disposal Schedule for Short-term Value Records - DA No. 2158* covers the disposal of short-term value records which are created by most agencies. These documents are usually of a trivial nature or of such short-term value that they do not support or contribute to the business functions of the agency.

Records not covered by these schedules, or other authorised disposal schedules, should be disposed of according to the current Tasmanian Archive & Heritage Office procedures for unscheduled records.

Preservation of records

Section 10 (1) (a) of the *Archives Act 1983* requires agencies to preserve records until they are dealt with under the Act. This places a statutory obligation on agencies to ensure that all records, regardless of format, remain accessible while they are in the custody of the agency.

Permanent records

All disposal classes of records identified as having 'PERMANENT' status in this schedule should be transferred to the Archives Office 25 years after the date of creation. Agencies may make application to the Tasmanian Archive & Heritage Office for earlier transfer of particular groups of records and the Tasmanian Archive & Heritage Office may also initiate an earlier transfer arrangement.

Records for transfer should be arranged and described in accordance with any instruction provided by the Tasmanian Archive & Heritage Office.

Temporary records

All records identified as having 'TEMPORARY' status in this schedule will have a disposal action which is the authorised date for destruction. These disposal actions specify minimum retention periods. Temporary records can be kept as long as the agency wishes following the expiration of the specified period, but the provisions of the *Archives Act 1983* regarding their proper care and custody will still apply to them.

Frequently the disposal actions will refer to **'after action completed'** which means after completion of the transaction to which the records relate. The disposal action **'destroy when reference ceases'** authorises the destruction of records when all business needs to refer to the records have ceased.

Destruction of records

The destruction method chosen for records authorised for destruction in this schedule should be appropriate to the medium in which the record exists. It is the responsibility of the agency to ensure that the identified records are actually destroyed, and that this process is confidential and secure. The following issues should be considered before destruction of any documents.

Right to Information

Right to Information legislation prescribe rights and processes for access to documents held by government agencies. If a request for access under the legislation has been lodged, all records relevant to the request, regardless of whether they are due for destruction, must be identified and preserved until action on the request and any subsequent reviews are completed.

Personal Information Protection

Personal Information Protection legislation provides appropriate safeguards for government agencies in collecting and handling individual's personal information, creating statutory obligations and a right to make a privacy complaint. If an application is in progress, all records relevant to the application must be identified and preserved until the action and any subsequent actions are completed.

Other investigations or inquiries

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

Records relating to indigenous people

Key recommendations of the Bringing Them Home Report 1997 relate to the need for the identification, preservation, indexing, management and access to records relating to Indigenous individuals, families and/or communities in accordance with established privacy principles.

Records relating to indigenous families and communities or which document links between indigenous people and localities are not to be destroyed and should be the subject of consultation with the Tasmanian Archive & Heritage Office.

Native title

If a native title claim is in progress, all documents relevant to the claim must be identified and preserved until the action and any subsequent actions are completed.

Registration of destruction

Central to the accountability process built into the disposal schedules is the requirement that agencies maintain a *Register of Records Destroyed*. It is important to recognise that the formal evidential record of destruction is contained in this registration process. The register is to be made available to the State Archivist (or his nominee) on request.

The register must be clearly identified as the *Register of Records Destroyed* (under Section 20 (2) (b) of the *Archives Act 1983*) and should include the name of the agency. The register can be the same used for registering destructions authorised under other disposal schedules. A sample format indicating the required elements for the register and related procedures are available on the Tasmanian Archive & Heritage Office website.

1.1.1	**SUMMARISED AND EPHEMERAL DOCUMENTATION** This section covers the 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 disposal class (e.g. summary of patient observations entered in the patient record is sentenced according to 2.1.1). It is expected that destruction under this section will be a normal administrative routine and it is not necessary to enter it in the Register of Records Destroyed. *See the Disposal Schedule for Short-term Value Records – DA No. 2158 for duplicate documentation.* ANY DESTRUCTION PRACTICE OR PROCEDURE UNDER THIS SECTION MAY BE SUSPENDED FOR SPECIAL TYPES OF DOCUMENTATION AT THE DIRECTION OF THE STATE ARCHIVIST WHERE IT IS CONSIDERED THAT SUCH RECORDS MAY BE OF CONTINUING VALUE TO THE AGENCY OR THE ARCHIVES OFFICE.	
1.1.0	**Observations**	
1.1.1	Records including: • daily fluid balance record; • frequent observations; • respirator record; • remaining monitor strips after editing and mounting or summarising in the patient record for electrocardiogram (ECG), eectroencephalogram (EEG), electromyogram (CTG); *Edited and mounted or summarised records are sentenced according to 2.1.1, 2.1.2, 2.1.3, 2.2.1, 2.2.2, or 2.3.1.*	TEMPORARY Destroy when information has been transcribed, summarised or edited.
1.2.0	**Nursing Care Plans**	
1.2.1	Records which are constantly revised and where revisions obliterate previous entries.	TEMPORARY Destroy when reference ceases

2.0.0 INDIVIDUAL PATIENT RECORDS

See 3.0.0 for special categories of individual patient records. Where these documents are filed in the individual patient record, the patient record must be retained for the periods specified in section 3.0.0.

N.B. Access on behalf of a patient or deceased includes any use made of the record or access to the record for any purpose concerning the patient or deceased, such as in the provision of a report to another health care worker or agency, access under subpoena, or inspection by the patient or deceased's next of kin. (Access for research or for the education of health professionals would not be counted as use "on behalf of the patient").

2.1.0 Patient Records – Acute Care Hospitals

Documents relating to individual in-patients, out-patients and casualty or accident and emergency patients in Acute Care Hospitals.

Acute Care Hospitals are listed in Schedule A of the Medicare Agreement. A copy of this agreement is available from the Acute Care Program of the Department of Community and Health Services.

Documents include:

- admission (form);
- ante-natal or pre-natal treatment;
- authority for removal of tissue after death for transplant of for anatomical purposes, and for post-mortem;
- autopsy or post-mortem (report);
- casualty or 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 having legal privilege - See 2.5.1;*
- detail records;
- discharge (includes final diagnosis, operative procedures; summary or letter; and discharge at own risk or against medical advice);
- doctor's or physician's orders;
- examination or physical examination;
- history (medical and social); of patient, or family);
- investigation reports (including graphs, flow sheets, laboratory and diagnostic reports, edited electrocardiogram (ECG), electromyogram (EMG), electroencephalogram (EEG) and cardiotociogram (CTG monitor strips, and fluid balance summary. *For remaining parts of monitor strips and for fluid balance work sheets - See Observations (1.1.0).*
- medical certificate (hospital copy of certificate issued to patient);
- 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 Nursing Care Plans 1.2.0)*;
- observations (includes vital signs, intensive care, head injury);
- obstetric (record);
- perinatal or newborn (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;
- short-stay treatment;
- surgical procedure or operation (includes pre-operative check-lists, anaesthetic records, instruments and swab count records, post-anaesthetic records, post-operative observations); therapeutic treatment (includes anti-coagulant, diabetic, dialysis, electric shock therapy (EST) or electro-convulsive therapy (ECT);
- therapeutic procedure;
- transfer of patient.

2.1.1	Records of discharged patients and outpatients. *A random sample of 1 in 1,000 individual patient files is to be retained permanently as per 2.1.1. A selected sample may also be retained.*	TEMPORARY Destroy 15 years after last attendance or last access on behalf of Patient (provided patient has attained the age of 30 years).
2.1.2	Records relating to patients who have died while in the hospital. *A random sample of 1 in 1,000 individual patient files is to be retained permanently as per 2.1.4.. A selected sample may also be retained.*	TEMPORARY Destroy 10 years after date of death or last access on behalf of deceased.
2.1.3	Casualty or Accident and Emergency Patient Records of any public hospital which does not have a formally constituted outpatient department and which files its outpatient notes separately from the individual patient record. Includes patients who were dead on arrival. Information includes the date and time of arrival, description of significant clinical, laboratory and radiological findings, details of treatment, time of discharge, attending medical officer.	TEMPORARY Destroy 7 years after attendance.
2.1.4	Sample of Individual Patient Records. *A sample of records in 2.1.1 and 2.1.2 should be taken in accordance with the Guidelines included in the Interpretation section.*	PERMANENT Transfer following culling of files due for destruction.
2.2.0	**Inpatient Records – Extended Care Facilities** Documents as listed under 2.1.0 relating to inpatients/residents in Extended Care Facilities. Does not include inpatients/residents in facilities for the disabled.	
2.2.1	Records of patients discharged from the Extended Care facility.	TEMPORARY Destroy 10 years after last attendance or last access on behalf of patient (provided patient has attained age of 25 years).
2.2.2	Records relating to patients who have died while in the Extended Care facility.	TEMPORARY Destroy 10 years after date of death or last access on behalf of deceased.
2.3.0	**Non-Inpatient Records – Extended Care Facilities** Includes day hospitals, day centres and domiciliary care services.	
2.3.1	Client records.	TEMPORARY Destroy 7 years after last attendance or official contact between facility and client (including access on behalf of client) (provided client has attained age of 25 years).
2.4.0	**Community Health Records**	
2.4.1	Records relating to clients of community health centres including records for unregistered clients (i.e. clients who are only "visitors", clients who are screened without follow-up, potential clients or clients who referred elsewhere).	TEMPORARY Destroy 7 years after last attendance or official contact between facility and patient (including access on behalf of the client) (provided the client has attached the age of 25 years).

2.5.0	**Documents Having Legal Privilege** Includes correspondence between the public hospital and solicitors or legal defence organisations regarding a patient of the public hospital. Such correspondence should be filed separately from the individual Patient Records.	
2.5.1	Documents having legal privilege relating to patients.	TEMPORARY Destroy 15 years after resolution of the legal matter.
3.0.0	**SPECIAL CATEGORIES OF INDIVIDUAL PATIENT RECORDS** Because of the special requirements of records identified in the following classes, they are usually stored separately from the hospital's main (unit) record for that patient. **Where the documents are filed in the individual patient record, the patient record must be retained for the periods specified in this section.**	
3.1.0	**Artificial Insemination and In-vitro Fertilisation**	
3.1.1	Case records of each individual person or family unit, including consent to in-vitro fertilisation or artificial insemination and use of semen, ova or embryos and withdrawal of consent.	TEMPORARY Destroy 75 years after action completed.
3.2.0	**Sexual Assault**	
3.2.1	Records of Sexual Assault Clinics filed separately from the individual inpatient record.	TEMPORARY Destroy 25 years after action completed.
4.0.0	**PATIENT INDEXES, REGISTERS AND LISTS**	
4.1.0	**Master Patient Index** The Master Patient Index (electronic or manual) which records the names of patients who have been admitted to the public hospital, extended care facility or community health centre is the key to locating the individual patient record in a numerical filing system by linking the patient's name to the hospital identification number. It may also include the names of patients who have attended as outpatients or as casualty or accident and emergency patients.	
4.1.1	Master patient index containing names of patients, the patient's hospital identification number (unit record number or UR No.), date of birth, sex, address and, in some cases, other details.	PERMANENT
4.2.0	**Disease and Operation Index.** Disease and Operation Index (electronic or manual) which records, for each disease or condition and operation procedure code number, selected items of patient information for each inpatient diagnosed as having that disease or condition, or recorded as having undergone that operation or procedure in the period covered by the index.	
4.2.1	Disease and Operation Index containing the patient's, record number, patient's name, sex, age, date of admission, length of stay, discharge status and destination, the responsible doctor or unit (name or code identifier), the ward, and other disease, condition, operation and procedure codes related to that admission.	PERMANENT

4.3.0	**Physicians' Index** Index (electronic or manual) which records, for each practitioner with admitting rights, the inpatients attended by that practitioner during the period covered by the index.	
4.3.1	Physicians' index recording the patient's record number and all disease, condition, operation and procedure codes related to that admission. Information may include patient's name, sex, age, date of admission, length of stay and discharge status and destination.	TEMPORARY Destroy when reference ceases.
4.4.0	**Number Register** Register (electronic or manual) listing 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.	
4.4.1	Number Register where the Master Patient Index (4.1.1) does not exist and the Number Register provides an alternative source of information.	PERMANENT
4.4.2	Number Register where the information in the Number Register is duplicated in the Master Patient index (4.1.1) and the Master Patient Index exists.	TEMPORARY Destroy when reference ceases.
4.5.0	**Admission Register** Register (electronic or manual) listing in date order each patient admitted. Information will include date of admission and name of patient.	
4.5.1	Register listing date of admission and name of patient. Information may include time of admission, patient's record number, address, sex, date of birth, next of kin, admitting diagnosis, discharge date and length of stay.	PERMANENT
4.6.0	**Discharge Register (EDP or Manual)** Register listing in date order each in-patient discharged. Information will include date of discharge and patient's name. Information may include patient's record number, discharge diagnosis and length of stay.	
4.6.1	Discharge Register where the Admission Register (4.5.1) does not exist and the Number Register provides an alternative source of information or where Admission Register does not contain discharge information.	PERMANENT
4.6.2	Discharge Register where the information is in the Admission Register (4.5.1) and the Admission Register exists.	TEMPORARY Destroy when reference ceases.
4.7.0	**Casualty or Accident and Emergency Register** Register (electronic or manual) listing in date and time order, each attendance at the casualty or accident and emergency department.	
4.7.1	Register listing date of attendance and name of patient. Information may include time of attendance, patient's sex, age, address, reason for attendance (e.g. diagnosis, symptom, injury) and ou5tcome or follow-up agreement.	TEMPORARY Destroy 7 years after date of last entry in register.
4.8.0	**Birth (Labour Ward) Register** Register (electronic or manual) listing in date order, each birth occurring in the hospital. *See 9.0.0 for statutory notifications regarding births.*	
4.8.1	Register listing date and time of birth, mother's name, sex of baby and names of medical and nursing staff in attendance. Information may include mother's record number, age and address.	PERMANENT

4.9.0	**Death Register** Register (electronic or manual) listing in date order each death occurring in the facility. *See 9.0.0 for statutory notifications regarding deaths.*	
4.9.1	Register listing date and time of death and name of patient. Information may include patient's sex and age, cause of death and name of medical officer.	PERMANENT
4.10.0	**Operation or Theatre Register** Register (electronic or manual) listing in date and time order, each operation or procedure carried out in the theatre.	
4.10.1	Register listing date, serial number of operation, time, patient's name, sex, age and record number, diagnosis and operative procedure, name of surgeon, assistant surgeon and anaesthetists, signatures of surgeon and anaesthetists, any anaesthetic complications and remarks.	PERMANENT
4.11.0	**Cancer Registrations** *See 9.3.1 for hospital copy of the notification to the Cancer Registry.*	
4.11.1	Annual listing (electronic or manual) of Cancer registrations.	TEMPORARY Destroy when reference ceases.
4.12.0	**Ward Register**	
4.12.1	Register (electronic or manual) listing in date order, reception of each in-patient into the ward. Information will include date of reception and name of patient.	TEMPORARY Destroy when reference ceases.
4.13.0	**Lists of Patients**	
4.13.1	In-patient Admission and In-Patient Discharge List (electronic or manual). *See 4.5.0 where no Admission Register is kept.* *See 4.6.0 where no Discharge Register is kept.*	TEMPORARY Destroy when reference ceases.
4.13.2	Outpatient List, Outpatient Attendance List, Appointment Book or Appointment Sheets.	TEMPORARY Destroy when reference ceases.
4.13.3	Death List *Does not apply to Death Register – See 4.9.0*	TEMPORARY Destroy when reference ceases.
4.13.4	Operation or Theatre List or Schedule. *Does not apply to Operation or Theatre Register – See 4.10.0*	TEMPORARY Destroy when reference ceases.
4.14.0	**Bed Return or Daily In-Patient Census**	
4.14.1	Records of the number of in-patients present in the ward at the census time and lists any in-patients who have been admitted or transferred in since the previous census time and any in-patients who have been discharged or transferred out or who have died since the previous census time.	TEMPORARY Destroy when audit requirements have been satisfied.

4.15.0	**Group Evaluation Reports**	
4.15.1	Register (electronic or manual) of groups, activities and programmes run in each Community Health Centre.	PERMANENT
5.0.0	**PATHOLOGY LABORATORY RECORDS AND DIAGNOSTIC MATERIAL** The disposal actions in classes 5.4.0 and 5.9.0 are those specified in the National Pathology Accreditation Advisory Council's "Retention of Laboratory Records and diagnostic Material (December 1983). The disposal actions I n classes 5.4.0 – 5.8.0 are subject to statutory requirements of State or Commonwealth, for example, to meet the current or future statutory requirements for payment of Commonwealth Medical Benefits.	
5.1.0	**Register of Specimens** Registers (electronic or manual) which record specimens collected or received. Information will include specimen number or other identification, laboratory procedure number or other identification, patient identification, doctor's name, date specimen was received, date specimen was examined and by whom, and condition of specimen if unsatisfactory. *See 5.1.1 if one register is kept for all types of specimens.* *See 5.2.0 to 5.8.0 if individual registers are kept for different types of specimen.*	
5.1.1	Register of Specimens collected or received which records all types of specimens and is used to locate reports, samples blocks, slides, film, cultures, swabs and other material in classes 5.2.0 - 5.8.0.	TEMPORARY Destroy 14 years after date of last entry in register.
5.2.0	**Autopsy or Post Mortem Records**	
5.2.1	Autopsy or Post-mortem Reports – Original diagnostic report should be filed in the individual patient record.	TEMPORARY Sentence according to 2.1.2 or 2.2.2
5.2.2	Autopsy or Post-mortem Reports – Duplicates	TEMPORARY Destroy 10 years after date of autopsy or post-mortem.
5.2.3	Blocks and Slides	TEMPORARY Destroy when reference ceases.
5.2.4	Registers (electronic or manual) used to locate reports, blocks and slides in 5.2.2 and 5.2.3.	TEMPORARY Destroy 10 years after date of last entry in register.
5.3.0	**Blood Alcohol Records** *See 9.1.0 for statutory health reports fulfilling obligations under the Alcohol and Drug Dependency Act and Road Traffic Act (Alcohol and Drugs) Act 1970.*	
5.3.1	Documents concerning taking of blood sample.	TEMPORARY Destroy 7 years after date of taking blood.
5.3.2	Register (electronic or manual) of blood samples listing the serial number of the container, of the blood sample, date and time blood sample was taken and name of person from whom sample was taken (or, where name of person is not known, sufficient information to enable the same to be identified with the person).	TEMPORARY Destroy 7 years after date of last entry in register.

5.3.3	Declarations by a legally qualified medical practitioner as to the grounds for not taking a sample of blood.	TEMPORARY Destroy 7 years after date of declaration.
5.3.4	Results (negative and positive).	TEMPORARY Destroy 7 years after date of taking blood.
5.4.0	**Clinical Biochemistry, Immunology and Blood Bank Records**	
5.4.1	Original Diagnostic Report: The original diagnostic report should be filed in the individual patient record. If the cumulative reporting system is used, a copy of the report should be filed in the individual patient record and sentenced accordingly. The original cumulative report should be retained in the Pathology Department and sentenced according to 5.4.2 Duplicate Diagnostic Reports.	TEMPORARY Sentence according to 2.1.1, 2.1.2, 2.1.3, 2.2.1, or 2.2.2.
5.4.2	Duplicate Diagnostic Reports including justification for examination of samples (which may be the request form).	TEMPORARY Destroy 3 months after date of examination.
5.4.3	Samples of Serum, Plasma, Other Body Fluids and Other Materials Examined.	TEMPORARY Destroy 7 days after date of examination.
5.4.4	Registers (Electronic or Manual) used to locate reports and samples in 5.4.2 and 5.4.3.	TEMPORARY Destroy 3 months after date of last entry in register.
5.4.5	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 the quantity in each batch, date of transfusion, identification date of issue to ward, and blood group of the product (if applicable).	TEMPORARY Destroy 20 years after date of last entry in register.
5.4.6	Statements by person intending to donate blood.	TEMPORARY Destroy 14 years after action completed.
5.5.0	**Cytology Records** Insert scope note to describe the activity *See 2.1.0 etc. (add see references as required)*	
5.5.1	Diagnostic Reports of Slides. Original diagnostic report should be filed in the individual patient record. If the cumulative reporting system is used, a copy of the report should be filed with individual patient record and sentenced accordingly. The original cumulative report should be retained in the Pathology Department and sentenced according to 5.5.2 or 5.5.4 Duplicate Diagnostic Reports.	TEMPORARY Sentence according to 2.1.1, 2.1.2 or 2.2.2.
5.5.2	Duplicate Diagnostic Reports of Slides showing evidence of malignancy or possible malignancy, including justification for examination of slides (which may be the request form).	TEMPORARY Destroy 14 years after date of examination.
5.5.3	Slides showing evidence of malignancy or possible malignancy.	TEMPORARY Destroy 14 years after date of examination.
5.5.4	Duplicate Diagnostic Reports of Slides not showing evidence of malignancy or possible malignancy, including justification for examination of slides (which may be the request form).	TEMPORARY Destroy 2 years after date of examination.

5.5.5	Slides not showing evidence of malignancy or possible malignancy.	TEMPORARY Destroy 2 years after date of examination.
5.5.6	Registers (Electronic or Manual) used to locate reports and slides described in 5.5.2 and 5 5.3.	TEMPORARY Destroy 14 years after date of last entry in register.
5.5.7	Registers (Electronic or Manual) used to locate reports and slides described in 5.5.4 and 5.5.5. *See 5.5.6 for reports and slides showing evidence of malignancy or possible malignancy (as described in 5.5.2 and 5.5.3)*	TEMPORARY Destroy 2 years after date of last entry in register.
5.6.0	**Haematology Records**	
5.6.1	Original Diagnostic Reports. Original diagnostic report should be filed in the individual patient record. If the cumulative reporting system is used, a copy of the report should be filed in the individual patient record and sentenced accordingly. The original cumulative report should be retained in the Pathology Department and sentenced according to 5.6.2 or 5.0.6 Duplicate Diagnostic Reports.	TEMPORARY Sentence 2.1.1, 2.1.2, 2.1.3, 2.2.1, 2.2.2.
5.6.2	Duplicate Diagnostic Reports of Blood Samples and Films where a significant initial or altered diagnosis is made or where the negative result is significant to the Patient, including justification for examination (which may be the request form).	TEMPORARY Destroy 1 year after date of examination.
5.6.3	Blood Films relating to 5.6.2	TEMPORARY Destroy 1 year after date of examination.
5.6.4	Blood Samples relating to 5.6.2.	TEMPORA;RY Destroy 7 days after date of examination.
5.6.5	Duplicate 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, including justification for examination (which may be the request form).	TEMPORARY Destroy 3 months after date of examination.
5.6.6	Duplicate 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, including justification for examination (which may be the request form).	TEMPORARY Destroy 7 days after date of examination.
5.6.7	Registers (Electronic or Manual) used to locate reports, blood samples and films described in 5.6.2, 5.6.3 and 5.6.4.	TEMPORARY Destroy 1 year after date of last entry in register.
5.6.8	Registers (Electronic or Manual) used to locate reports, blood samples and films in 5.6.5 and 5.6.6. *See 5.6.7 for registers used to locate reports, blood samples and films described in 5.6.2, 5.6.3 and 5.6.4.*	TEMPORARY Destroy 3 months after date of last entry in register.

5.7.0	**Histopathology and Bone Marrow Records**	
5.7.1	Original Diagnostic Reports: Original diagnostic report should be filed in the individual patient record. If the cumulative reporting system is used a copy of the report should be filed in the individual patient record and sentenced accordingly. The original cumulative report should be retained in the Pathology Department and sentenced according to 5.7.2 Duplicate Diagnostic Reports.	TEMPORARY Sentence according to 2.1.1, 2.1.2, 2.1.3, 2.2.1, 2.2.2.
5.7.2	Duplicate Diagnostic Reports, including justification for examination (which may be the request form).	TEMPORARY Destroy 14 years after date of examination.
5.7.3	Slides and Blocks	TEMPORARY Destroy 14 years after date of examination.
5.7.4	Unblocked Tissue.	TEMPORARY Destroy when reference ceases (when referring doctor has reviewed laboratory report).
5.7.5	Registers (Electronic or Manual) used to locate reports, slides, blocks and tissue described in 5.7.2, 5.7.3 and 5.7.4.	TEMPORARY Destroy 14 years after date of last entry in register.
5.8.0	**Microbiology Records**	
5.8.1	Original Diagnostic Reports: Original diagnostic report should be filed in the individual patient record. If the cumulative reporting system is used, a copy of the report should be filed in the individual patient record and sentenced accordingly. The original cumulative report should be retained in the Pathology Department and sentenced according to 5.8.2 Duplicate Diagnostic Reports.	TEMPORARY Sentence according to 2.1.1, 2.1.2, 2.1.3 or 2.2.2.
5.8.2	Duplicate Diagnostic Reports, including justification for examination of such material (which may be the request form).	TEMPORARY Destroy 3 months after date of examination
5.8.3	Cultures and Stained Slides.	TEMPORARY Destroy when reference ceases (when referring doctor has reviewed laboratory report).
5.8.4	Swabs, Specimens and Other Material Examined.	TEMPORARY Destroy 3 days after date of examination.
5.8.5	Registers (Electronic or Manual) used to locate reports, cultures, stained slides, swabs, specimens and other material described in 5.8.2, 5.8.3 and 5.8.4.	TEMPORARY Destroy 3 months after date of last entry in register.
5.9.0	**Request Forms**	
5.9.1	Request Forms where justification for examination has not been written into diagnostic report.	TEMPORARY Sentence according to appropriate category i.e. 5.4.2, 5.5.2, 5.5.5, 5.6.2, 5.6.6, 5.7.2 or 5.8.2.

5.9.2	Request Forms where justification for examination has been written into diagnostic report.	TEMPORARY Destroy when reference ceases.
6.0.0	**PHARMACY RECORDS** The drug or medication order written by the medical practitioner or dentist and the record of administration written by nursing staff should be filed in the individual patient record and sentenced according to 2.1.1, 2.1.2, 2.1.3, 2.2.1 or 2.2.2.	
6.1.0	**Drugs of Addiction Records** The following records are held in the Pharmacy Department. The retention of these records is required under the *Poisons Regulations Act 1975.*	
6.1.1	Orders to Supply and prescriptions issued by a medical practitioner or dentist.	TEMPORARY Destroy 2 years after date of supplying substance.
6.1.2	Drug of Addiction Requisition Book.	TEMPORARY Destroy 2 years after last entry in book.
6.1.3	Authorisation from a medical practitioner or dentist to administer a drug of addiction.	TEMPORARY Destroy 2 years after date of administering substance.
6.1.4	Drug of Addiction administration book.	TEMPORARY Destroy 2 years after date of last entry in book.
6.1.5	Drug of Addiction register	TEMPORARY Destroy 2 years after last entry in register.
6.1.6	Drug of Addiction stock check sheets.	TEMPORARY Destroy 2 years after date of disposal of stock.
6.2.0	**Restricted Substance Records** The following records are held in the Pharmacy Department. The retention of these records is required under the Poisons Regulations Act 1975.	
6.2.1	Orders to Supply and prescriptions issued by a medical practitioner or dentist.	TEMPORARY Destroy 2 years after date of supplying substance.
6.2.2	Requisition book.	TEMPORARY Destroy 2 years after date of last entry in book.
6.2.3	Authorisation from a medical practitioner or dentist to administer a restricted substance.	TEMPORARY Destroy 2 years after date of administering substance.
6.2.4	Records of administration of a restricted substance.	Temporary Destroy 2 years after date of last administering substance.
6.2.5	Emergency supply records.	TEMPORARY Destroy 2 years after date of transaction.
6.2.7	Invoices, orders or other documentation including prescription records in respect of sale, supply, dispensing, distribution, administering or use of a restricted substance.	TEMPORARY Destroy 2 years after date of transaction.

6.3.0	**Potent Substances Records** The following records are held in the Pharmacy Department. The retention of these records is required under the *Poisons Regulations Act 1975.*	
6.3.1	Prescriptions.	TEMPORARY Destroy 2 years after date of dispensing of substance.
7.0.0	**IMAGING RECORDS; DIAGNOSTIC RADIOLOGY, NUCLEAR MEDICINE, ULTRA-SOUND, COMPUTED TOMORGRAPHY, MAGNETIC RESONANCE IMAGING.** The disposal actions in classes 7.1.0 - 7.3.0 are subject to statutory requirements of State or Commonwealth, for example to meet the current or future statutory requirements for payment of Commonwealth Medical Benefits.	
7.1.0	**Diagnostic Reports**	
7.1.1	Original Diagnostic Reports: Original imaging service report should be filed in the individual patient record.	TEMPORARY Sentence according to 2.1.1, 2.1.2, 2.1.3, 2.1.1 or 2.2.2.
7.1.2	Duplicate Diagnostic Reports, including justification for examination (which may be the request form).	TEMPORARY Destroy 5 years after date of report.
7.2.0	**Film and Similar Visual Materials**	
7.2.1	Radiographic films or diagnostically equivalent images. These should be retained in the Radiology Department.	TEMPORARY Destroy (recycle) 5 years after last attendance for diagnostic imaging.
7.3.0	**Registers**	
7.3.1	Registers (Electronic or Manual) used to locate reports, film and similar materials in 7.1.1, 7.1.2 and 7.2.1.	TEMPORARY Destroy when all film and similar visual materials registered have been destroyed.
7.4.0	**Request Forms**	
7.4.1	Request forms where justification for examination has not been written into another record.	TEMPORARY Destroy 5 years after date of report.
7.4.2	Request Forms where the justification for examination is incorporated into another record.	TEMPORARY Destroy when reference ceases.

8.0.0	**PHOTOGRAPHS** Excludes diagnostic images. *See 6.0.0. If photograph is filed in the individual patient record, sentence according to 2.1.1, 2.1.2, 2.1.3, 2.2.1 or 2.2.2.*	
8.1.0	**Reference Collection**	
8.1.1	Reference Collection including transparencies and prints.	TEMPORARY Destroy when reference ceases.
9.0.0	**NOTIFICATIONS AND REPORTS**	
9.1.0	**Statutory Notifications Regarding Births and Deaths** Copies of records fulfilling obligations under the *Notification of Births Act 1966* and *Registration of Births and Deaths 1895*, and *Coroners Act 1957.*	
9.1.1	Copy of the notification filed in the individual patient record	TEMPORARY Sentence according to 2.1.1, 2.1.2, 2.1.3, 2.2.1 or 2.2.2
9.1.2	Hospital copy of the Statutory Notification	TEMPORARY Destroy 1 year after date of notification.
9.2.0	**Statutory Health Reports** Copies of records fulfilling obligations under: • *Public Health Act 1962* for notifiable diseases such as Aids, sexually transmitted diseases, infectious diseases, and some serious diseases. • *Alcohol and Drug Dependency Act* and *Road Traffic Act (Alcohol and Drugs) Act 1970* for drink driving offences. • *Child Protection Act 1974* for suspected child abuse. • *Hospital Act 1918* for reports to Department of Community & Health Services.	
9.2.1	Copy of the Health Report filed in the individual patient record.	TEMPORARY Sentence according to 2.1.1, 2.1.2, 2.1.3, 2.2.1 or 2.2.2.
9.2.2	Hospital's copy of the Health Report	TEMPORARY Destroy 1 year after action completed.
9.3.0	**Non Statutory Notifications.**	
9.3.1	Hospital copy of the notification to the Cancer Registry	TEMPORARY Destroy 1 year after action completed.

INDEX TO DISPOSAL CLASSES

This index is an alphabetical listing of the subjects directly referred to in the Disposal Class titles and as such it does not include comprehensive subject cross references.