Office of the
State Archivist

# DISPOSAL SCHEDULE FOR CLIENT HEALTH RECORDS – V6

Disposal Authorisation DA2426

**Version 6.0**
**August 2024**

Tasmanian Government

## CONTACT US

Office of the State Archivist

www.osa.tas.gov.au

osa@libraries.tas.gov.au

03 6165 5581

# Table of Contents

**Authorisation** ..... **3**
**Introduction** ..... **7**
**Disposal Schedule** ..... **10**
**01.00 Aged Care** ..... **10**
**02.00.00 Child & Youth Services** ..... **11**
**03.00 Community Health Care** ..... **15**
**04.00 Correctional Health** ..... **15**
**05.00 Alcohol and Drug Services** ..... **15**
**06.00 Genetic Health Conditions (previously Inherited Diseases)** ..... **15**
**07.00.00 Mental Health Services** ..... **17**
**08.00 Occupational Medicine** ..... **27**
**09.00 Sexual Health** ..... **27**
**10.00 Health Assistance Schemes** ..... **27**
**11.00 Patient and Client Information** ..... **28**
**12.00 Rehabilitation** ..... **34**
**13.00.00 Cancer Screening Programs** ..... **34**
**14.00 Immunisation Services** ..... **35**
**15.00 Diagnostic and Testing Services, including Non-Coronial Autopsy Services** **38**
**16.00 Sexual Assault Forensic Examination Services** ..... **39**

# Authorisation

Under Section 20 (2) (b) of the *Archives Act 1983* (Tas), I 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.

**Ross Latham**

**State Archivist**

| Version | Date | Comments |
|---|---|---|
| 6.0 | 28/08/2024 | Authorised release |

## Document Development History

| Version | Date | Comments |
|---|---|---|
| 1.0 | 19/11/2013 | Initial release with a single function: 13.00.00 Screening Services |
| 2.0 | 17/03/2014 | Second function added: 10.00.00 Patient Transport |
| 3.0 | 09/2014 | Additional function: 06.00.00 Inherited Diseases |
| 4.0 | 05/2015 | Additional function: 02.00.00 Child and Youth Services |
| 5.0 | 17/11/2016 | Additional function: 07.00.00 Mental Health Services |

| | | |
|---|---|---|
| In subsequent releases the version numbers were changed (no explanation) and the pre-existing version 4.0 was cited as version 1.0. Document development histories in the next few versions were presented as the following: | | |
| 1.0 | 11/2013 | Initial release: sections 2.0.0; 6.0.0; 10.0.0; 13.0.0 |
| 2.0 | 11/2016 | Section 7.0.0 |
| 2.1 | 18/12/2017 | Minor amendment to the disposal trigger for 02.02.03 (Parenting Centre Records) |
| 2.2 | 30/08/2021 | OSA formatting changes |

| | | |
|---|---|---|
| 6.0 | 28/08/2024 | Amendments made (compared with v2.2) are listed in the following table |

## Summary of Amendments in this schedule

| Function number | Function title | Summary of changes |
|---|---|---|
| 01.00 | Aged Care | New<br>Consists of 2 classes:<br>01.01 Assessment services<br>01.02 Program Participant records |
| 02.00 | Child and Youth Services | Remaining activities:<br>• Child health and parenting services<br>• Family violence, counselling and support<br>• Youth Health<br>Removed (See DA2585):<br>• Adoptions and permanent care<br>• Child protection<br>• Out of home care<br>• Youth Detention<br>• Youth Justice - Community |
| 03.00 | Community health care | No longer required (covered in Patient and Client Information 11.00) |
| 04.00 | Correctional health | No longer required (covered in Patient and Client Information 11.00) |
| 05.00 | Alcohol and drug services | No longer required (covered in Patient and Client Information 11.00) |
| 06.00 | Genetic health conditions (previously Inherited diseases) | Expanded |
| 07.00 | Mental health services | Updated |
| 07.04.02 | 'Controversial' client files | Removed (covered by Client Health records – Secure Mental Health Unit - 07.04.03) |
| 07.04.06 | Huntington's Disease clinical Client files | Removed (covered by Chronic and Long-term Health Conditions 11.02) |
| 07.04.07 | Pre-vocational training to facilitate progress to employment | Removed (covered in *Disposal Schedule for Disability and Community Services* DA2499 / 3.2 |
| 07.04.13 | Client Property | Removed |
| 07.04.14 | Client Records – social welfare assistance | New |
| 08.00 | Occupational health | No longer required (covered in Patient and Client Information 11.00) |
| 09.00 | Sexual health | No longer required (covered in Patient and Client Information 11.00) |
| 10.00 | Health assistance schemes | Expanded |

| | | |
|---|---|---|
| 11.00 | Patient and client information | New |
| 12.00 | Rehabilitation | No longer required (covered in Patient and Client Information 11.00) |
| 13.00 | Screening programs | Now covers just cancer screening. Other screening programs are covered in *Disposal Schedule for Health Administration* (DA2525 / 07.00) |
| 14.00 | Immunisation services | New |
| 15.00 | Diagnostic and testing services, including non-coronial autopsy services | New |
| 16.00 | Sexual assault forensic examination services | New |

## Brief History of the Development of *Client Health Records (*DA2426)

In 2013 it was decided that DA2426 would be written and authorised one function at a time. This was so that disposal could start in these areas without having to wait for the final product.

The structure of the schedule was established at the initiation of the project and was fixed (although there was some variation with time).

Although Mental Health was considered the highest risk area, the decision to start with Screening Services was made (because initial work had already been done).

In 2020, Emma Savage (consultant) was approached to review and update DS 20 (Public Hospital Patient and Medical Records). She suggested that these records be merged with DA2426. She was employed to write the remaining functions and in the process there were significant changes made. These changes are summarised above.

In 2022, it became clear that there was significant opposition to records of patients with chronic conditions being managed differently (and having a longer retention) from those of patients with acute conditions (11.02 and 11.03). The issue was primarily centred around problems identifying legacy records which were held in secondary storage. Eventually, it was agreed to authorise a single class disposal schedule to accommodate these legacy, hard-copy records. This is *Disposal Schedule for Legacy Client Health Records* (DA2583)

This schedule will be withdrawn at the end of 2032.

OSA also recognised that the areas covered in the function: Child & Youth Services (02.00.00), which Emma Savage was not asked to review, are high risk and of great public interest. These include:

- Adoptions and Permanent Care,
- Child Protection,
- Out of Home Care,
- Youth Detention and
- Youth Justice - Community.

In addition, none of these are now in the purview of the Department of Health. These have been taken out of this schedule and will be authorised in a separate schedule (*Disposal Schedule for the Care and Protection of Children and Young People* DA2585).

# Introduction

**Disposal Schedules are the State Archivist's ongoing permission to dispose of records.**

They identify:

- which records have a permanent retention and will be transferred to the Tasmanian Archives
- the minimum time that temporary records need to be kept before they can be destroyed.

## Authority

Tasmanian government organisations covered by the *Archives Act 1983* (Tas) can only dispose of records with the written permission of the State Archivist.

"Disposal of records" means destroying them, removing them from the creating organisation, or transferring them to the Tasmanian Archives.

## Records Covered

This disposal authority for Client Health Records updates and expands coverage for the various forms of client health information created and collected by hospitals and health services.

It includes coverage for information created and collected when:

- delivering health treatment and care services,
- providing assistance to a person to access health care, equipment or aids such as prostheses,
- profiling a person's health condition and its mode of expression in that person, including for health conditions which have been inherited, to better tailor the treatment and care, or health advice given to that person,
- planning, delivering and/or monitoring the progress of individual recovery and rehabilitation regimes,
- developing and monitoring tailored personal programs of ongoing proactive health management and/or preventative approaches,
- providing health services which assist a person in ameliorating or avoiding the ongoing effects of a health issue, such as assisted reproductive services to those experiencing barriers to fertility.

This Disposal Authority replaces coverage previously available under:

- DS 20 – *Disposal Schedule for Patient and Medical Records*
- DS 23 – *Disposal Schedule for Sexual Health Programs*
- DS 35 – *Disposal Schedule for Disability Support Services (Spectacle Assistance Scheme)*
- DS 36 – *Disposal Schedule for Oral Health*
- DA 2383 – *Disposal Authority for Aged Care Assessments*

For full coverage of the delivery of health services to a client, this Disposal Authority should be read in conjunction with:

- *Disposal Schedule for Health Administration Records* (DA2525).

## Responsibility for Review

You are responsible for monitoring legislative or regulatory changes which may affect disposal of records covered by this schedule. If this happens, please tell the Office of the State Archivist because we may need to review the disposal schedule.

## Unscheduled Records

Unscheduled records are records not covered in this or any other disposal schedule and include all pre-1960 records.

Please contact us to discuss procedures to manage these records.

## You Cannot Destroy Records, Even if the Retention Period has Passed, if:

- they are the subject of a **records retention notice** ("disposal freeze") issued by the State Archivist or your organisation; or
- they may be required for an **investigation, inquiry or Royal Commission which** is in **progress** or expected; or
- they may be needed as **evidence** in a current or expected legal matter; or
- they are needed for applications in progress under the ***Personal Information Protection Act 2004*** **(Tas)** or ***Right to Information Act 2009*** **(Tas)**; or
- there is a **native title claim** in progress.

If any of these apply, identify all relevant records and keep them until the matter and any following reviews, appeals or actions are complete. This may be longer than retention periods in this schedule.

## Records Of First Nations People

Keep records of First Nations' people if they document cultural connection to place and/or the impact of government policies on individuals, families and communities.

## More Information

- **Outsourcing**:
  You are responsible for recordkeeping, even if your organisation outsources a function.
- **Retention periods are minimums**:
  The retention periods in this schedule are minimum periods.
  - You can keep records longer where there is a business need for them.
  - Take a risk-based approach when deciding how long to keep records.
- **Destruction of records**:
  Destroy temporary records securely and appropriately to the format or medium. Record their destruction in your *Register of Records Destroyed*.
- **Transfer of records**:
  Transfer permanent records to the Tasmanian Archives, in line with procedures.
- **Legal deposit**:
  Follow National edeposit (NED) guidelines for lodging print, digital and audio-visual publications, including government publications, under legal deposit legislation.
- **Legislation**:
  This disposal schedule is issued under the *Archives Act 1983* (Tas).

Also, consider the legislation relevant to your own organisation to make sure you've met all recordkeeping requirements.

## Other Disposal Schedules

You can use other disposal schedules with this schedule, including:

- *Disposal Schedule for Common Administrative Functions* (DA2157)
- *Disposal Schedule for Short Term Value Records* (DA2158)
- *Disposal Schedule for Source Records* (DA2159)
- *Disposal Schedule for Statutory Governing Bodies* (DA2508)
- other disposal schedules relevant to your organisation.

# Disposal Schedule

| Reference | Description | Status And Disposal Action |
|---|---|---|
| **01.00** | **Aged Care**<br>The function of providing aged care services. Covers both legacy records from when aged care was a state based function as well as records of continuing services provided as a supplement to the commonwealth government aged care function.<br>Includes:<br>• aged care assessments<br>• residential care services<br>• seniors day care programs<br>• aged care respite programs.<br>Notes re use of this section:<br>• All records of homecare nursing, medical treatment and care, and attendance at health services should be sentenced under section 11 of this disposal authority, including patient services received from clinics or services that specialise in geriatric health and related fields such as memory loss or decline etc.<br>• All records of mental health care should be sentenced under section 7 of this disposal authority.<br>• Records resulting from funded service arrangements with the commonwealth government to deliver aged care services in Tasmania should be sentenced using relevant federal disposal authorities i.e. My Aged Care and residential aged care facility health records.<br>• Attendees at seniors day care and aged care respite programs that are under the age range defined by the commonwealth government to receive aged care funding are funded by the state, therefore records of those clients should be sentenced in accordance with this section of this disposal authority.<br>**See** *Common Administrative Functions (DA2157) v4* 13.00.00 PROPERTY MANAGEMENT for all aspects of managing and maintaining a residential care facility.<br>**See** *Common Administrative Functions (DA2157) v4* 05.00.00 FINANCIAL MANAGEMENT for records of client payments for day care, respite programs and any other aged care support program eg community meals schemes.<br>**See** *Common Administrative Functions (DA2157) v4* 01.22.00 COMMUNITY RELATIONS - Public Reaction for records of complaints | |

| | | |
|---|---|---|
| **01.01** | **Assessment Services**<br>Records of the assessment of patients for eligibility for aged care services, and determinations regarding the level of care required. | TEMPORARY<br>Destroy 7 years after last date on file |
| **01.02** | **Program Participant Records**<br>Records of clients participating in aged care programs such as seniors day care services or aged care respite services. Includes records of:<br>• participant details<br>• emergency contact details<br>• dietary requirements<br>• medication requirements (for medication which the participant will be due to receive while participating in the services)<br>• care requirements (eg assistance in the bathroom, with dressing etc.)<br>• dates of participation<br>• activity preferences<br>• travel/transport arrangements<br>• referrals to other aged care programs for respite care or occupational therapy etc. that the participant may benefit from. | TEMPORARY<br>Destroy 7 years after last date of service |
| **02.00.00** | **Child & Youth Services**<br>The function of planning, implementing and coordinating a range of services and programs directed to enhancing the independence, wellbeing and sufficiency of Children and Youth.<br>**See** *Care and Protection of Children and Young People* DA2585 for Adoptions and permanent care; Child protection; Out of home care; Youth detention; Youth justice - Community. | |
| **02.01.00** | **Adoptions and Permanent Care**<br>The provision of permanent family placements for children who cannot be cared for by their biological family as well as counselling and access to information and the facilitation of reunion where this is the wish of both parties. Also includes financial assistance.<br>**See**: *Care and Protection of Children and Young People* (DA2585) | |
| **02.02.00** | **Child Health & Parenting Services**<br>The provision of services promoting child health, including growth and developmental assessments, parent support and information as well as early intervention services. | |
| **02.02.01** | **Childhood client health records**<br>Records of:<br>• support and assessments offered to parents of children aged 0-5 years | TEMPORARY<br>Destroy 25 years after date of birth of child |

| | | |
|---|---|---|
| | • growth and development assessments for children aged 0-5 years<br>• Wetaway program for children aged 5-18 years<br>Records may include:<br>• child health data<br>• postnatal depression assessment<br>• breastfeeding assessment<br>• consent to share and release information<br>• child health assessments<br>• case details and review<br>• correspondence<br>• progress notes. | |
| **02.02.02** | **CHaPS Statewide register**<br>CHaPS Statewide Register. Information may include:<br>• client details<br>• site visit details entered by clinicians<br>• date of attendance. | TEMPORARY<br>Destroy 25 years after date of birth of child |
| **02.02.03** | **Parenting Centre Records**<br>Records relating to the parenting of babies and young children (0-5 years). Records may include:<br>• registration form<br>• client intake form<br>• issues summary<br>• progress notes<br>• consent for sharing information<br>• enhanced summary form. | TEMPORARY<br>Destroy 7 years after action completed provided the client has attained the age of 25 years |
| **02.02.04** | **Child Development Records**<br>Records relating to the comprehensive multidisciplinary assessment and referral for children (0-5 years) who are suspected of having delays in one or more areas of their development. Records may include:<br>• registration form<br>• progress notes<br>• consent form<br>• correspondence. | TEMPORARY<br>Destroy 25 years after date of birth of child |
| **02.02.05** | **Health Direct Telephone Triage Service**<br>Database recording calls to the Health Direct Telephone Triage Service, and advice given. | TEMPORARY<br>Destroy 7 years after action completed |
| **02.03.00** | **Child Protection**<br>The activity of providing services and strategies for the ongoing protection of children and young people through prevention and early intervention services and out of home | |

| | | |
|---|---|---|
| | care. This includes collaboration with community organisations under the *Children, Young Persons and their Families Act 1997* (Tas), and previously under the *Infants Welfare Act 1960* (Tas), and the *Child Protection Act 1974* (Tas).<br>**See:** *Care and Protection of Children and Young People* (DA2585) | |
| **02.04.00** | **Family Violence Counselling and Support**<br>The provision of specialised counselling and support to children, young people and adults affected by family violence. | |
| **02.04.01** | **Child and Young Person's Program (CHYPP) files.**<br>Client files. Records may include:<br>• personal and demographic information<br>• case notes, planning and summaries<br>• referrals<br>• external reports<br>• financial record of assistance. | TEMPORARY<br>Destroy 110 years after date of birth |
| **02.04.02** | **Adult Program (FVSCC) files**<br>Client files. Records may include:<br>• personal and demographic information<br>• case notes and summaries<br>• incident reports<br>• legal orders<br>• housing requests<br>• financial records<br>• police referrals<br>• police reports<br>• hospital reports. | TEMPORARY<br>Destroy 110 years after date of birth |
| **02.05.00** | **Out of Home Care**<br>The provision of placement options for children who are in need of care and protection away from their parents or guardians.<br>**See**: *Care and Protection of Children and Young People* (DA2585) | |
| **02.06.00** | **Youth Detention**<br>The provision of safe and secure care for young people on remand and in detention<br>**See**: *Care and Protection of Children and Young People* (DA2585) | |
| **02.07.00** | **Youth Health**<br>The provision of information, education, support, referral and counselling to 11-25 year olds to help them make informed life and health decisions. | |
| **02.07.01** | **Youth Health Client records**<br>Records relating to health and wellbeing services and support provided to young people aged 11-25. Records may include: | TEMPORARY<br>Destroy 7 years after last date of access provided the client has attained the age of 25 years |

| | | |
|---|---|---|
| | • intake form<br>• assessment records<br>• consent to share information<br>• correspondence<br>• progress notes<br>• pregnancy test documents<br>• youth health funding applications.<br><br>**See:** 11.00 or 07.04.00 depending on the nature of the service provided | |
| **02.07.02** | **Youth Health Client records - Sexual Assault**<br><br>Records relating to health and wellbeing services and support provided to young people aged 11-25 where sexual assault counselling has been provided or allegations of sexual assault have been made. Records may include:<br><br>• intake form<br>• assessment form<br>• consent to share information form<br>• correspondence with other agencies<br>• progress notes<br>• pregnancy test documents<br>• Youth Health Funding applications.<br><br>**Note**: Sexual Assault Forensic Examination Services Client Files are covered in 16.01 | TEMPORARY<br><br>Destroy 110 years after date of birth |
| **02.07.03** | **Minutes of Meetings - Clients**<br><br>Minutes of Meetings to discuss clients. Meetings may include:<br><br>• client intake meetings<br>• client review staff meetings.<br><br>Note: go to 11.00 or 07.04.00 depending on the nature of the treatment | TEMPORARY<br><br>Destroy 7 years after action completed |
| **02.07.04** | **Staff Diaries and Notebooks**<br><br>Staff Diaries and Notebooks. Information may include:<br><br>• appointment details<br>• client notes. | TEMPORARY<br><br>Destroy after reference use ceases |

| | |
|---|---|
| **02.08.00** | **Youth Justice – Community**<br><br>Records created in the provision of support to Courts in the supervision, diversion and rehabilitation of young people in the Community under Tasmanian youth justice legislation.<br><br>**See**: *Care and Protection of Children and Young People* (DA2585) |
| **03.00** | **Community Health Care**<br><br>**Note:** This function is now covered in Patient and Client Information **11.00** |
| **04.00** | **Correctional Health**<br><br>**Note:** This function is now covered in Patient and Client Information **11.00** |
| **05.00** | **Alcohol and Drug Services**<br><br>**Note:** This function is now covered in Patient and Client Information **11.05** |
| **06.00** | **Genetic Health Conditions (previously Inherited Diseases) - EXPANDED**<br><br>Services related to inherited diseases are offered by the Tasmanian Clinical Genetics Service (TCGS), or specialist medical practitioners/clinics.<br><br>**Inherited Disease Diagnosis using Genetic Testing**<br><br>TCGS provide a clinical service for the diagnosis, management, counselling and support of individuals and families with a wide range of genetic disorders. In general TCGS services are eligible only to those patients who can demonstrate vulnerability to an inherited disease i.e. a relative has been diagnosed with an inherited disease which the patient may carry, but for which they have not otherwise been diagnosed.<br><br>**Clinical Diagnosis of Inherited Diseases**<br><br>Not all cases of inherited disease are diagnosed using genetic testing. In cases where a patient is unaware they may have inherited a disease, diagnosis may not occur until the symptoms of the disease are exhibited/become pronounced. For example, a person with Huntington's Disease may be unaware they are a carrier and first present as a young patient with a mild mental health condition. They may only be diagnosed with Huntington's Disease later in life once a collection of behavioural and other symptoms have manifested and progressed to a point where a clinician is able to make a clinical diagnosis.<br><br>**Prenatal Diagnosis and Pregnancy Counselling Services.**<br><br>A range of services are provided by health clinics such as obstetrics and gynaecological services, women's health clinics and TCGS to people who are pregnant or are planning a pregnancy who have demonstrable reason/s to suspect they or their foetus are a carrier of/likely to have genetic health condition, whether due to an inherited disease being in the family, or some other risk factor which put the foetus at increased risk eg the pregnant woman is over the age of 35 years.<br><br>Note: many obstetrics and gynaecological services and women's health clinics will undertake sample collection and then use a clinical genetic service, such as Victorian Clinical Genetics Services (VCGS) or TCGS to process the test sample and provide a result. |

| | | |
|---|---|---|
| | **See** *Function records of Health Administration (DA2525) v2* 07.00 Health Condition screening (including Newborn) for records of health screening programs. | |
| **06.01** | **Genetic family records**<br>Records documenting the diagnosis, management, counselling and support of individuals and families with a wide range of genetic disorders.<br>Records may include:<br>• referrals<br>• 'Progeny' - electronic pedigree program<br>• access database<br>• genetic test results<br>• correspondence<br>• counselling notes<br>• demographic data.<br>**NOTE:** For records of prenatal diagnosis and/or pregnancy counselling see **06.02** Prenatal Diagnosis and Pregnancy Counselling Services.<br>**NOTE:** For records of treatment and care of the symptoms of the inherited disease see **11.00** Patient and Client Information. | PERMANENT<br>Retain in Agency |
| **06.02.00** | **Prenatal Diagnosis and Pregnancy Counselling Services**<br>Prenatal services offered to patients who are pregnant or planning a pregnancy, including:<br>• counselling and carrier testing to clarify risk of genetic conditions<br>• prenatal diagnosis for various genetic conditions<br>• counselling regarding genetic issues of infertility and in-vitro fertilisation<br>• counselling regarding screening tests before or during pregnancy<br>• diagnosis and counselling when a birth defect is detected during pregnancy. | |
| **06.02.01** | **Records of Continuing Value**<br>Records of continuing value summarising the function of prenatal diagnosis and pregnancy counselling services where the summary is a statewide deidentified dataset of Tasmanian screening results.<br>Note: This deidentified dataset is to be collected from all prenatal diagnosis screening programs run in Tasmania, whether state-based or run in Tasmania as part of a national program.<br>This dataset may be combined with the newborn screening dataset produced under DA2525 Records of Health Administration, Class 7.1 Health Condition Screening Deidentified Dataset. | PERMANENT<br>Retain as State Archives |

| | | |
|---|---|---|
| **06.02.02** | **Long-term Records**<br>Records of long-term value documenting the prenatal diagnosis and pregnancy counselling service, comprising summary information, including identifying information, of the samples, test results and outcome. Also known as control records. | TEMPORARY<br>Destroy 100 years after action completed |
| **06.02.03** | **Medium-term Records**<br>Records of medium-term value documenting the delivery of pregnancy counselling services to patients, including:<br>• counselling and carrier testing to clarify risk of genetic conditions<br>• prenatal diagnosis for various genetic conditions<br>• counselling regarding genetic issues of infertility and in-vitro fertilisation<br>• counselling regarding screening tests before or during pregnancy<br>• diagnosis and counselling when a birth defect is detected during pregnancy.<br>Note: In this class the patient is regarded as being the parent/s, not the unborn child. | TEMPORARY<br>Destroy 15 years after last date of counselling provided patient is 33 years old |
| **06.02.04** | **Short-term Records**<br>Records of short-term value documenting the prenatal diagnosis and pregnancy counselling service:<br>• samples and their documentation eg forms completed at the time of sample collection<br>• test process notes, charts and observations<br>• copies of system produced result documentation held by the laboratory or testing service<br>• copies of result analysis or interpretation carried out by the laboratory or testing service to transform system produced graphs, charts. images or quantitative results into diagnostic results (i.e. a result from which a specialist can make a diagnosis or put towards a diagnostic position (if the results are not clear-cut))<br>• copies of any explanatory documentation sent out with test results.<br>**Note**: The test results and associated documentation delivered to the requesting specialist are patient information and fall under **06.02.03.** | TEMPORARY<br>Destroy 2 years after action completed |
| **07.00.00** | **Mental Health Services**<br>The function of providing specialist clinical mental health services to individuals with a severe mental illness. | |

| | | |
|---|---|---|
| **07.01.00** | **Access and Support**<br>The activity associated with facilitating access to Mental Health services and programs including assessment, triage and intervention. | |
| **07.01.01** | **Records of facilitating access to Mental Health Services**<br>Records of facilitating access to Mental Health Services including assessment, triage and intervention. Examples include records of the:<br>• Access Mental Health (and other preceding mental health helpline services)<br>• Crisis Assessment Triage Team (CATT)<br>• Mobile Intensive Support Team (MIST).<br>Records may include:<br>• risk assessment and screening<br>• referral to other services<br>• crisis interview (counselling)<br>• progress record<br>• correspondence<br>• helpline database.<br>All records of contacts are covered by this class, irrespective of whether they proceeded to be admitted/taken into services following the contact or not. | TEMPORARY<br>Destroy 25 years after date of last contact provided the client has obtained the age of 43 years |
| **07.01.02** | **Records of informal contacts**<br>**NOTE**: Records which were in this class in the previous version of this schedule are now included in **07.01.01**<br>This includes where clients are not formally accepted into the service and a formal client record is not created. Records may include:<br>• referrals received but client not accepted into service or did not attend<br>• description of presenting problem<br>• redirection to another service<br>• recommendations/advice given<br>• triage information<br>• enquiry details - method, assistance requested, information provided to enquirer<br>• date and time of contact. | TEMPORARY<br>Destroy 2 years after date of last action |
| **07.02.00** | **Forensic Case Management**<br>The activity of managing individuals with a mental illness who are involved with, or at risk of becoming involved with the criminal justice system.<br>Includes assessment and planning individual case outcomes. | |

| | | |
|---|---|---|
| **07.02.01** | **Client records of the Court Liaison Service**<br>Records created in the assessment and identification of individuals before the judiciary who may not be fit to plead and/or require diversion into a mental health setting through the Mental Health Diversional List. Records may include:<br>• mental health assessment<br>• court dates<br>• pending charges and other legal information<br>• court outcomes<br>• progress notes<br>• client demographic details<br>• discharge summaries<br>• correspondence<br>• summary sheet. | TEMPORARY<br>Destroy 25 years after action completed |
| **07.02.02** | **Client records of the Community Forensic Case Management Service**<br>Client records of the Community Forensic Case Management Service. Records may include:<br>• mental health assessment<br>• counselling notes<br>• advice given<br>• referrals to other services<br>• case management plan<br>• case management review<br>• Chief Psychiatrist approved forms. | TEMPORARY<br>Destroy 25 years after action completed |
| **07.02.03** | **Client records of the former Forensic Mental Health Prison Service**<br>Includes records where the original information is not stored in the Prison Health Inmate File. Records may include:<br>• registration<br>• progress notes<br>• correspondence<br>• assessment<br>• history. | TEMPORARY<br>Destroy 25 years after action completed |
| **07.02.04** | **Legal Files**<br>Records of clients of Forensic Mental Health Services pertaining to any legal matter, including records sourced in the writing of court reports. Records may include:<br>• request for court report by judge or magistrate | TEMPORARY<br>Destroy 25 years after action completed |

| | | |
|---|---|---|
| | • source documents, eg police reports, victim/witness impact statement, criminal history/record, any document relevant to the case<br>• copy of final report<br>• mental Health Tribunal hearings, reports and outcomes<br>• probation orders<br>• legal outcomes of court<br>• correspondence regarding any legal matter<br>• warrants. | |
| **07.03.00** | **Reporting and Monitoring**<br>The activity of reporting and review of the management, health and treatment of clients and patients under the *Mental Health Act 2013* (Tas). | |
| **07.03.01** | **Monthly reports**<br>Monthly reports on long term involuntary inpatients. Report prepared for the Mental Health Tribunal and Chief Civil Psychiatrist on the accommodation and treatment of long term involuntary inpatients. Records may include:<br>• patient name<br>• date of admission<br>• details of treatment and care given during the month. | TEMPORARY<br>Destroy 5 years after action completed |
| **07.03.02** | **Weekly Reports to Mental Health Tribunal**<br>Weekly report on each forensic patient to the Mental Health Tribunal. Records may include:<br>• admission and discharge dates<br>• the exercise of visitation rights (including any denial or restriction of those rights)<br>• searches, detentions, arrests (whether of visitors or other persons)<br>• seizures of property (whether from the patient or visitors)<br>• police visits<br>• the exercise of telephone rights (including any denial or restriction of those rights)<br>• the exercise of correspondence rights (including any denial or restriction of those rights). | TEMPORARY<br>Destroy after administrative use ceases |
| **07.03.03** | **Client mail**<br>Registers documenting the management of client mail in the Secure Mental Health Unit. This includes:<br>• Register of Prohibited Addressees<br>• Refused (Outgoing) Mail Register<br>• Refused (Incoming) Mail/Contraband Register.<br>Records may include: | TEMPORARY<br>Destroy 7 years after action completed |

| | | |
|---|---|---|
| | • details of addressee's who have asked not to receive mail<br>• details of restraint and family violence orders<br>• reasons for refusal of mail incoming and outgoing<br>• list of contraband items<br>• reasons for refusal of contraband items. | |
| **07.03.04** | **Legal Order tracking**<br>Working documents created in the process of tracking Mental Health Act Legal Orders. Records may include:<br>• name of patient<br>• THCI (Tasmanian Health Client Index) number<br>• type of order<br>• service type, eg inpatient, forensic<br>• expiry date of current order<br>• number of days before order expires<br>• date of order hearing<br>• working notes of legal orders coordinator<br>• renewal of order status<br>• date renewal will take place<br>• issues register<br>• outdated orders<br>• legacy guardianship orders. | TEMPORARY<br>Destroy 12 months after action completed |
| **07.04.00** | **Patient/Client Treatment and Care**<br>The activity of providing services by health professionals for the benefit of the patient/client such as:<br>• medical examination<br>• assessment<br>• diagnosis<br>• treatment care<br>• education.<br>**See Also*:* 07.02.00** Forensic Case Management (MENTAL HEALTH SERVICES).<br>**NOTE:** See **11.20** for records of Huntington's Disease patients<br>**See** *Common Administrative Functions (DA2157) v4* 05.00.00 FINANCIAL MANAGEMENT for records of client payments, bills and receipts.<br>**See** *Disability and Community Services (DA2499)* 3.2 Other Records of Community Services Client Management for records of pre-vocational training. | |
| **07.04.01** | **Client records - inpatient, residential or extended care facility**<br>Records of patients/clients receiving mental health care and/or treatment in an inpatient, residential or extended care facility. Records may include:<br>• registration, admission and discharge records | TEMPORARY<br>Destroy 25 years after date of last contact |

| | | |
|---|---|---|
| | • medical records, certificates and charts<br>• consents, permissions and authorisations for treatment and care<br>• treatment and care checklists<br>• observations and clinical notes<br>• legal orders<br>• tribunal and Chief Psychiatrist correspondence and instructions<br>• risk assessments<br>• incident reports, etc. | |
| **07.04.02** | **REMOVED**<br>This class has been removed.<br>It covered 'controversial' client files in the previous version of this schedule.<br>**NOTE:** All client files of the Secure Mental Health Unit are to be treated as one retention category under **07.04.03**. | |
| **07.04.03** | **Client records - Secure Mental Health Unit**<br>Records of patients/clients admitted to a forensic mental health service. Includes:<br>• registration, admission and discharge records<br>• medical records, certificates and charts<br>• consents, permissions and authorisations for treatment and care<br>• treatment and care checklists<br>• observations and clinical notes<br>• legal orders<br>• tribunal and Chief Psychiatrist correspondence and instructions<br>• risk assessments<br>• incident reports, etc.<br>**NOTE**: See **07.04.09** for records of private practitioners working with patients/clients in Wilfred Lopes Centre. | TEMPORARY<br>Destroy 25 years after date of last contact |
| **07.04.04** | **Client records - non-admitted, outpatient or community health (over 18 years)**<br>Records of clients/patients receiving mental health care in a non-admitted, outpatient or community health setting where the patient/client is aged 18 years and over. Includes client records of:<br>• Dementia Behaviour Management Advisory Services (DBMAS)<br>• Dementia Support Unit<br>• Community Dementia (North)<br>• Community Adult Mental Health Services | TEMPORARY<br>Destroy 25 years after date of last contact |

| | | |
|---|---|---|
| | • Acute Care Team (ACT)<br>• Mental Health Co-response Service (PACER)<br>• Homeless Outreach Service<br>• Older Persons Mental Health Service Community<br>• Memory Clinic<br>• Roy Fagan Day Centre<br>• rehabilitation<br>• Access Mental Health triage assessment (and other preceding mental health gateway/triage services)<br>• emergency department attendances<br>• social welfare counselling.<br><br>Records may include:<br><br>• patient registration<br>• chief psychiatrist approved forms<br>• mental health services checklist<br>• care plan<br>• medication information<br>• assessment<br>• counselling notes<br>• correspondence<br>• clinical reviews<br>• progress notes<br>• transfer of care/clinical handover<br>• case closure/client discharge<br>• incident report forms<br>• consent forms. | |
| **07.04.05** | **Client records - non-admitted, outpatient or community health (under 18 years)**<br><br>Records of client/patients receiving mental health care in a non-admitted, outpatient or community health setting where the patient/client is under the age of 18. Includes client records of:<br><br>• child and adolescent mental health services - including family and parental therapy<br>• emergency department attendances<br>• social welfare counselling.<br><br>Records may include:<br><br>• patient registration<br>• strengths and difficulties questionnaires<br>• care plan<br>• discharge letter<br>• progress notes<br>• medication information<br>• assessment | TEMPORARY<br><br>Destroy 25 years after date of last contact, provided patient has reached 43 years of age |

| | | |
|---|---|---|
| | • counselling notes<br>• correspondence<br>• case closure/client discharge<br>• consent forms<br>• Chief Psychiatrist approved forms<br>• attendance and appointment information<br>• assessments and questionnaires. | |
| **07.04.06** | **REMOVED**<br>This class has been removed.<br>It covered Huntington's Disease clinical client files in the previous version of this schedule.<br>**NOTE:** These files are now covered by class **11.02** PATIENT AND CLIENT INFORMATION - Chronic and Long-term Health Conditions. | |
| **07.04.07** | **REMOVED**<br>This class has been removed.<br>In the previous version of this schedule, it covered pre-vocational training of clients to facilitate their progress into employment.<br>**See**: *Disability and Community Service (*DA2499) / 3.2 Community Services Client Management. | |
| **07.04.08** | **Client records - University Psychology Clinic**<br>Client records of the University Psychology Clinic. Records may include:<br>• alert sheet<br>• registration form<br>• clinical progress notes<br>• history<br>• assessments and reports<br>• referral<br>• client therapy history<br>• consent form<br>• care plan<br>• intake interview<br>• correspondence<br>• discharge/transfer summary. | TEMPORARY<br>Destroy 25 years after date of last contact provided the client has reached the age of 43 years |
| **07.04.09** | **Client records from Private Practitioner - Wilfred Lopes**<br>Records of clients in the Wilfred Lopes Centre, which were produced by private practitioners who have been consulted for additional input into the treatment of the client. Records may include:<br>• patient information sheet | TEMPORARY<br>Destroy 10 years after date of transfer to Agency |

| | | |
|---|---|---|
| | • progress notes<br>• correspondence.<br><br>**NOTE:** See **07.04.03** for Client records in secure mental health unit | |
| **07.04.10** | **Client records - psychiatric institutions**<br><br>Records of patients/clients in psychiatric institutions established and managed by the Agency until their closure in November 2000. Facilities include Royal Derwent Hospital and Willow Court. Records may include:<br><br>• alert sheet<br>• patient registration<br>• admission and discharge dates<br>• leave dates<br>• date of death<br>• voluntary or involuntary status of patient<br>• Mental Health Act legal orders<br>• medical history<br>• examination<br>• clinical treatment<br>• progress notes<br>• medication charts<br>• periodic observations and examinations<br>• discharge summary/letters<br>• incident reports<br>• consent forms<br>• social worker client files<br>• client financial records<br>• restraint and seclusion summaries. | PERMANENT<br><br>Retain in State Archives |
| **07.04.11** | **Diaries and appointment books**<br><br>Personal or work diaries and appointment books where relevant information has been transferred to the client/patient's medical record. Records may include:<br><br>• details of appointments<br>• client contact details<br>• client attendance<br>• dates/times of meetings. | TEMPORARY<br><br>Destroy after administrative use ceases |
| **07.04.12** | **Patient/Client lists**<br><br>Patient/client lists. Records may include:<br><br>• appointment lists<br>• attendance sheets<br>• service provider client list<br>• client observation sheets (Secure Mental Health Unit) | TEMPORARY<br><br>Destroy after administrative use ceases |

| | | |
|---|---|---|
| | • client activity approval sheets (Secure Mental Health Unit)<br>• client canteen order lists (Secure Mental Health Unit). | |
| **07.04.13** | **REMOVED**<br>This class has been removed.<br>It covered records of client property in the previous version of this schedule. | TEMPORARY<br>Destroy 12 months after administrative use ceases |
| **07.04.14** | **Client records - social welfare assistance**<br>Records of the provision of practical assistance to social welfare clients with tasks such as:<br>• finding crisis or temporary accommodation<br>• completing applications or registering for Centrelink and other government social support services/payments/grants<br>• setting up a bank account or organising finances<br>• joining a community social support group<br>• arranging support services for vulnerable citizens such as coupons, delivered meals, in-home care and support services, transport for shopping trips or medical appointments etc.<br>**NOTE:** For records of counselling services offered to social welfare clients, see **07.04.04** (adult clients) or **07.04.05** (child or adolescent clients). | TEMPORARY<br>Destroy 7 years after action completed |
| **07.05.00** | **Registration and Identification**<br>**NOTE:** This activity is now covered in **11.00** Patient and Client Information.<br>It is the activity of managing the identification, registration and client contact with services. | |
| **07.05.01** | **Patient Master Index/Register**<br>**NOTE:** Use **11.01** Patient Indexing and Registration, for records which would previously have been covered by this class | |
| **07.06.00** | **Restraint and Seclusion Registers**<br>See class descriptions. | |
| **07.06.01** | **Identified Patient Registers**<br>Restraint and Seclusion Registers - Summary Record. Records may contain:<br>• patient details (label)<br>• date/time of admission<br>• date of restraint/seclusion<br>• type of restraint<br>• time seclusion/restraint commenced | TEMPORARY<br>Destroy 100 years after date of birth of youngest entrant |

| | | |
|---|---|---|
| | • time seclusion/restraint ceased<br>• total time<br>• name and title of person approving. | |
| **07.06.02** | **Deidentified Summary Information**<br>A deidentified set of data recording the use of restraint and seclusion on patients as part of their treatment and care, for the purposes of:<br>• research into the application of these powers over an individual<br>• analysis and reporting over time on the use of these powers.<br>The dataset includes:<br>• date/time of admission<br>• date of restraint/seclusion<br>• type of restraint<br>• time seclusion/restraint commenced<br>• time seclusion/restraint ceased<br>• total time<br>• name and title of person approving. | PERMANENT<br>Retain as State Archives |
| **08.00** | **Occupational Medicine**<br>**NOTE:** This function is now covered in Patient and Client Information **11.00** | |
| **09.00** | **Sexual Health**<br>**NOTE:** This function is now covered in Patient and Client Information **11.00** | |
| **10.00** | **Health Assistance Schemes**<br>Schemes or programs which assist Tasmanian residents in accessing medical services, equipment and/or aids. Most provide financial assistance towards the cost of travel to specialist medical practitioners or specialist items such as prostheses.<br>Examples of schemes in operation include:<br>• Patient Travel Assistance Scheme (PTAS) provides financial assistance with travel and/or accommodation costs for Tasmanian residents to access a range of specialist medical services, where these services are not available locally<br>• Prostheses<br>• Podiatry aids such as inserts or custom made footwear<br>• Intraocular and other specialist vision aids (spectacles etc.)<br>• TasEquip for loans of medical aids and equipment<br>• Artificial Limb Scheme<br>• Lymphedema Garment Scheme.<br>Assistance may be provided in the form of:<br>• grants towards expenditure<br>• reimbursement of costs | |

| | | |
|---|---|---|
| | • provision of travel, accommodation, aids or services at no, or reduced, cost to the patient<br>• loan of equipment or aids.<br><br>**See** *Common Administrative Functions (DA2157) v4* 01.22.00 COMMUNITY RELATIONS - Public Reaction for complaints relating to applications made for patient travel assistance. | |
| **10.01** | **Assistance Records**<br><br>Client applications and decisions regarding provision of assistance. Records may include:<br>• application forms<br>• supporting documentation such as prescriptions, referrals to and letters from treating specialists, quotations etc.<br>• documentation showing eligibility such as financial assessments, health care card and other concessions, proof of residency etc.<br>• appointment or booking information eg for fittings<br>• receipts. | TEMPORARY<br><br>Destroy 7 years after action completed |
| **11.00** | **Patient and Client Information**<br><br>Medical and health service information about the treatment and care provided to patients of a hospital or health service. Covers patients and clients of the following services:<br>• emergency departments<br>• hospital admissions or outpatient presentations<br>• correctional health services including general practitioner health consultations<br>• alcohol and drug services<br>• occupational medicine<br>• sexual health clinics<br>• rehabilitation clinics<br>• allied health clinics<br>• community health care and outreach services<br>• community nursing services<br>• geriatric health clinics<br>• inherited diseases.<br><br>Includes related health services such as cognitive testing to assess capability to continue to hold a driver's licence eg following a brain injury.<br><br>**NOTE:** See **06.00** Genetic Health Conditions (previously Inherited Diseases) for patient information of the Genetics Service.<br><br>**NOTE:** See **07.04.00** Patient / Client Treatment and Care for patient information of Mental Health Services. | |

| | | |
|---|---|---|
| | **See** *Common Administrative Functions (DA 2157) v4* 10.00.00 LEGAL SERVICES for providing records of patient information as part of a response to claims or litigation<br><br>**See** *Common Administrative Functions (DA 2157) v4* 09.00.00 INFORMATION MANAGEMENT for requests for patient information made under Freedom of Information or Right to Information processes<br><br>**See** *Health Administration (DA2525) v2* 19.00 OCCUPATIONAL HEALTH SERVICES for records of staff occupational health files.<br><br>**See** *Health Administration (DA2525) v2* 18.00 PATIENT RECORDING for records of statutory registers, state or national datasets, birth registers, death registers etc.<br><br>**See** *Health Administration (DA2525) v2* 15.00 HEALTH SERVICE EQUIPMENT AND SUPPLIES MANAGEMENT for records of equipment and supplies sterilisation<br><br>**See** *Short-term Value Records (DA2158)* 01.01.10 Appointment Timetabling Records for appointment and booking records where the information is captured in a centralised admission or patient registration system | |
| **11.01** | **Patient Indexing and Registration**<br><br>Summary records which include:<br>• admissions to, and discharges from, care at a hospital or health service, including emergency departments<br>• master indices which capture unique identifying numbers or codes for patients, medical practitioners and/or types of treatment or care procedures eg disease or operations indices<br>• outpatient attendance and appointment books (where not captured in a centralised admission or patient registration system)<br>• master summary records of operations or operating theatre use. (**See:** *Health Administration* (DA2525) v2 17.02 WARD / FACILITY MANAGEMENT (INCLUDING STAFF HANDOVER) for operational copies of daily schedules and bookings used by staff to prepare the operating theatre and its equipment for the day.) | TEMPORARY<br><br>Destroy 50 years after date of last entry |
| **11.02** | **Chronic and Long-term Health Conditions**<br><br>Treatment and care records for those patients diagnosed with:<br>• a chronic condition caused by a health condition or disease (inherited or otherwise) that is persistent or otherwise long-lasting in its effects i.e. the patient is likely to experience some form of symptoms, or will need to follow a particular treatment and care program to avoid symptoms, for the remainder of their life, eg cardiovascular disease, diabetes, HIV, asthma, cerebral palsy, Huntington's Disease, motor neuron | TEMPORARY<br><br>Destroy 10 years after date of death or 100 years after date of birth. |

| | | |
|---|---|---|
| | disease, dementia, chronic kidney disease, chronic obstructive pulmonary disease etc.<br>• a long-term condition which requires a lengthy treatment program and/or follow up care or monitoring over a period of years, but which may ultimately be cured or remediated. Includes conditions which have a high risk of recurring (such as cancer), or conditions which are a long-lasting injury resulting from an acute episode (such as amputation following infection, partial paralysis following a stroke, or brain/spine injury following an accident).<br><br>Includes records of:<br>• initial treatment and care of any acute episode that results in a long-term condition, and subsequent treatment and care records for that condition, including rehabilitation services for long term injuries or symptoms<br>• diagnostic information and reports, clinical images and reports<br>• forward planning of treatment and care program phases, goals for recovery etc.<br>• clinical notes and recordings, including examinations, assessments and progress tests<br>• referrals and records of referred treatment and care phases eg chemotherapy, surgery, rehabilitation etc.<br>• allergies, sensitivities and other treatment parameters<br>• community/homecare nursing services<br>• care summaries<br>• prescription and medication details<br>• consent records (for treatment, information sharing, and any other purpose required to facilitate treatment and care)<br>• medical certificates<br>• counselling records (to assist the client in adapting to a life living with/surviving a chronic/long-term disease).<br><br>Examples of inherited disease include (this is not an exhaustive list):<br>• Huntington's Disease<br>• Parkinson's Disease<br>• Cystic Fibrosis<br>• Phenylketonuria<br>• Duchenne Muscular Dystrophy<br>• Tay-Sachs Disease<br>• Downs Syndrome<br>• Haemophilia | |

| | | |
|---|---|---|
| | • Marfan Syndrome. | |
| **11.03** | **Acute and Short-term Health Conditions**<br>Treatment and care records for those patients:<br>• diagnosed with an acute condition or illness which develops suddenly and lasts a few days or weeks and for which the patient is admitted to a hospital, eg bronchitis, heart attack, appendicitis etc. Includes short-term sexually transmitted infection which resolves when treated, and sexual dysfunction treatment<br>• that suffer a physical injury which when healed does not result in a chronic condition eg a broken bone, a gash or stab wound, a crushing injury<br>• that require a surgical procedure, whether it is part of a broader treatment plan for a chronic condition such as removal of a cancerous tumour, results from an acute incident such as a car accident, or repairs accumulated damage such as a hip or knee replacement<br>• that require a short-term program (generally under one year's duration) of outpatient treatment and care to address an injury or loss of physical function eg rehabilitation, physiotherapy, a course of injections etc.<br>• attending a medical imaging appointment or specialist procedure eg x-rays, dialysis, biopsy etc. where the overarching treatment and care of the patient is being managed by a referring medical practitioner, not the provider of the imaging or specialist procedure services, and the results will be reported back to the referring medical practitioner<br>• receiving inpatient dental treatment through a public hospital<br>• receiving palliative care, whether residential or in the home using community nursing services<br>• receiving transitional care in the home following a hospital admission<br>• of correctional health clinics receiving general practitioner and dental health services. Includes patients admitted to in-house wards or infirmaries for inpatient care<br>• accessing emergency care and treatment for conditions which do not require admission to hospital for further treatment or monitoring.<br>Includes records of cognitive function testing to assess capacity to continue to hold a drivers licence eg following a brain injury. | TEMPORARY<br>Destroy 15 years after last date of treatment or monitoring |

| | | |
|---|---|---|
| | Includes records of single instance health consultations/admissions for interstate or international travellers who seek medical treatment and care while temporarily in Tasmania.<br><br>Examples of patient information include:<br>• individual admission and discharge records (not summary registers of all patients)<br>• care summaries<br>• observations<br>• clinical notes and recordings, including examinations and assessments<br>• referrals<br>• diagnostic information and reports, clinical images and reports<br>• prescription details and medication charts<br>• community nursing records<br>• consent records (for treatment, information sharing, and any other purpose required to facilitate treatment and care)<br>• medical certificates<br>• counselling records.<br><br>**NOTE:** For outpatient oral health care see **11.07.** | |
| **11.04** | **Gender Health Services**<br><br>Treatment and care records for those patients receiving services for:<br>• gender variance and/or dysphoria<br>• gender change<br>• gender fluidity.<br><br>Services may include:<br>• counselling<br>• hormonal treatment<br>• referrals for surgery.<br><br>Note: Tasmanian patients may be referred to interstate clinics and service providers for specialist services such as gender surgery where there is no local provider, or local providers are experiencing long wait times. In such cases copies of, or reports which document and summarise, patient information produced/recorded by the interstate provider will be sent through to the referring Tasmanian practitioner for capture and use as part of the patient's ongoing record. | TEMPORARY<br><br>Destroy 100 years after date of birth |
| **11.05** | **Alcohol and Drug Services** | TEMPORARY<br><br>Destroy 25 years after date of last |

| | | |
|---|---|---|
| | Records of patients of alcohol and drug addiction treatment and care programs, including records of:<br>• referrals<br>• legal orders<br>• diagnostic reports<br>• registration, admission and discharge of an individual patient from services<br>• risk assessments and treatment and care plans<br>• treatment agreements<br>• counselling<br>• observations and clinical notes, including medical examinations<br>• prescriptions<br>• consents, permissions and authorisations. | contact, provided patient has reached 43 years of age |
| **11.06** | **Assisted Reproductive Services**<br>Client records of in-vitro fertilisation and artificial insemination services offered to patients with fertility/conception issues.<br>Includes client case management, consultation notes, testing and treatment of barriers to conception, consent records, selection and use of gametes or embryos, fertilisation/implant procedures etc. | TEMPORARY<br>Destroy 75 years after action completed |
| **11.07** | **Outpatient Oral Health**<br>Client dental health records including:<br>• dental health status<br>• health history (dental and medical where relevant)<br>• referrals<br>• test results and findings, including imaging (x-rays, photographs etc.)<br>• treatment and care observations and notes<br>• consents.<br>Note: Dental moulds and casts used for the purposes of constructing full or partial dentures, mouth guards, crowns, bridges and/or removal dental appliances etc. may be destroyed once reference ceases - these are treatment design aides rather than client health records.<br>**NOTE:** For inpatient dental health records see **11.03**. | TEMPORARY<br>Destroy 7 years after action completed, or patient is 25 years of age, whichever is later |
| **11.08** | **Routine or Low Value Patient / Client Records**<br>Low value patient information that:<br>• directly duplicates information captured on the patient file, or | TEMPORARY<br>Destroy 6 months after action completed |

| | | |
|---|---|---|
| | • is produced as a result of more detailed observation/consultation which is captured on the patient file, and/or<br>• is transactional i.e. relates to a patient but is not about the diagnosis, treatment and care of their health condition.<br><br>Examples include:<br>• medical certificates<br>• equipment or patient aid loans and returns<br>• patient personal property dockets.<br><br>Legacy forms of record included in this class are:<br>• books in which transactions are copied for operational purposes eg a loan book kept in the main office that duplicates information held in the equipment/aid register, or a register of patient property/valuables placed with the office/clinic manager for safe keeping while a patient is undergoing treatment etc.<br>• carbon copy books which hold a duplicate or triplicate copy of records issued and are not an original record of patient diagnosis, treatment or care. | |
| **12.00** | **Rehabilitation**<br><br>**NOTE:** This function is now covered in Patient and Client Information **11.00** | |
| **13.00.00** | **Cancer Screening Programs**<br><br>Department of Health operates various screening programs to minimise cancer mortality and morbidity through screening, early detection, community education and health promotion.<br><br>**See** *Health Administration (DA2525) v2* 07.00 HEALTH CONDITION SCREENING (including Newborn) for records of screening program other than for cancer, including samples and results | |
| **13.01.00** | **Cancer Screening**<br><br>Records documenting the provision of screening services to clients to minimise cancer mortality and morbidity through early detection, community education and health promotion. | |
| **13.01.01** | **Client files**<br><br>Client file. Records may include:<br>• scans and ultrasounds<br>• progress notes<br>• registration forms<br>• consents<br>• worksheets | TEMPORARY<br><br>Destroy 10 years after date of last screening |

| | | |
|---|---|---|
| | • assessment forms<br>• biopsy records<br>• histopathology audits<br>• treatment forms<br>• radiographers' forms<br>• discharge/restore forms<br>• general client correspondence<br>• imaging films (x-rays), requests, records, reports and recordings. | |
| **14.00** | **Immunisation Services**<br>The function of delivering vaccinations to members of the public via a hospital clinic or health service.<br>It includes legacy vaccination programs eg Tuberculosis (TB) clinic vaccinations, as well as new and current programs arising to provide protection to Tasmanians from disease eg meningococcal disease, COVID-19 strains etc.<br>It includes programs that deliver vaccinations onsite at the hospital or health service as well as those that provide travelling clinics eg visits to schools to vaccinate students.<br>This function complements public health immunisation programs delivered by councils.<br>**See** *Health Administration (DA2525) v2* 19.00 OCCUPATIONAL HEALTH SERVICES for records of hospital and health service staff vaccinations<br>**See** *Local Government (DA2200)* 24.11.00 Registration (Public Health) for records of vaccinations delivered by local government programs | |
| **14.01** | **Legacy Registers**<br>Registers that record the delivery of vaccinations to clients where there is no central Commonwealth register of the administration of vaccines.<br>It includes vaccines delivered:<br>• as part of national programs<br>• through school programs<br>• privately eg for influenza or travel.<br>Registers may include some or all of the following:<br>• name of client<br>• date of birth<br>• contact details<br>• parent/guardian details (for records of child clients)<br>• occupation and employer details (for records of adult clients who may be required by their employer to be vaccinated)<br>• date of vaccination/s<br>• immune response test results eg Mantoux test results prior to TB vaccination | TEMPORARY<br>Destroy 25 years after date of last entry |

| | | |
|---|---|---|
| | • consent details.<br><br>**Note**: The Australian Childhood Immunisation Register was established in 1996, and was expanded to form the Australian Immunisation Register (capturing records of both children and adults) in 2016. All vaccinations delivered via national or school programs after these dates will be captured on these registers, and any other register held by the service delivering the vaccination is a copy and may be destroyed in line with records of individual vaccinations.<br><br>**Note**: Not all vaccines delivered to Tasmanian citizens will be captured in registers held by hospitals, health services or local councils. For example, vaccines delivered by a General Practitioner (GP) prior to the establishment of Commonwealth registers may only be recorded on the patient file held by the GP. | |
| **14.02** | **Adult Vaccination Records**<br><br>Detailed records of vaccinations given to adults, including:<br>• client name and contact details, date of birth, emergency contact details etc.<br>• records of consent, including checklists of the delivery of information (eg handouts or verbal statements) to the client about possible side effects etc.<br>• records of pre-vaccination screening eg responses to questions about past medical history or immunisation history, health conditions the client may have, if they are/have been a close contact with someone with a particular disease, if they have travelled to certain countries/locations recently, etc.<br>• vaccine administration details: what dose was given, date/time of dose, dose batch number etc.<br>• practitioner details: name and details of the person delivering the vaccination<br>• clinic details: name and address of the clinic the vaccination was delivered at (includes details of travelling or temporary clinic locations)<br>• employer/occupation details where the vaccination is a workplace requirement<br>• wait and release details following a vaccination (where a client is asked to wait for a period of time before leaving the clinic to ensure any adverse reaction to a vaccination may be attended to promptly) (if collected)<br>• details of any adverse reaction and the response given<br>• any other relevant details eg if the client requested/was given a medical certificate to cover time taken to | TEMPORARY<br><br>Destroy 7 years after date of administration of the vaccine |

| | | |
|---|---|---|
| | receive the vaccination, or a vaccination confirmation certificate to take to an employer etc.<br><br>**Note**: Where a client has an adverse reaction that requires an ambulance, a follow-up visit to a general practitioner, and/or admission to hospital the records of subsequent treatment and care will be captured on the patient file/s of those services and does not need to be captured as part of the vaccination record. | |
| **14.03** | **Child Vaccination Records**<br><br>Detailed records of vaccinations given to children, including:<br><br>• client name and contact details, date of birth, parent/guardian name and contact details etc.<br>• records of consent, including checklists of the delivery of information (eg handouts or verbal statements) to the client/parent/guardian about possible side effects etc. Includes consent and vaccination information that has been sent home on behalf of the vaccine provider by schools to students/families prior to vaccination for signature/acknowledgement and return in order for a student to receive a vaccination at a school clinic.<br>• records of pre-vaccination screening eg responses to questions about past medical history or immunisation history, health conditions the client may have, if they are/have been a close contact with someone with a particular disease, if they have travelled to certain countries/locations recently, etc.<br>• vaccine administration details: what dose was given, date/time of dose, dose batch number etc.<br>• practitioner details: name and details of the person delivering the vaccination<br>• clinic details: name and address of the clinic the vaccination was delivered at (includes details of travelling or temporary clinic locations)<br>• wait and release details following a vaccination (where a client is asked to wait for a period of time before leaving the clinic to ensure any adverse reaction to a vaccination may be attended to promptly) (if collected)<br>• details of any adverse reaction and the response given<br>• any other relevant details eg if the parent/guardian requested/was given a medical certificate to cover time taken to bring their child for vaccination etc.<br><br>**Note**: Where a client has an adverse reaction that requires an ambulance, a follow-up visit to a general practitioner, and/or admission to hospital the records of subsequent treatment and care will be captured on the patient file/s of | TEMPORARY<br><br>Destroy 25 years after date of birth |

| | | |
|---|---|---|
| | those services and does not need to be captured as part of the vaccination record. | |
| **14.04** | **Vaccine Handling**<br>Records of the handling and storage of vaccines as part of the delivery of a vaccination program. Includes:<br>• storage and cold chain management<br>• handling, preparation and administration<br>• requisition and delivery management<br>• stock level monitoring and reporting, including expiry and discards (eg if a vaccine seal is broken, a pre-packed injection is faulty, cold chain failures etc.). | TEMPORARY<br>Destroy 2 years after action completed |
| **15.00** | **Diagnostic and Testing Services, including Non-Coronial Autopsy Services**<br>The function of analysing and determining the nature or cause of a patient's poor physical or mental health through diagnostic and testing services in order to determine the course of treatment/treatment options to be taken; or if undertaken post-mortem, to determine the cause of death or factors contributing to death (autopsy).<br>**Note**: Copies of diagnostic or testing services results/reports, including autopsy/post-mortem reports which form part of the patient history are to be sentenced in accordance with the relevant patient information retention classes.<br>Pathology service types include:<br>• Anatomical Pathology (Histopathology)<br>• Cytology<br>• Haematology<br>• Clinical Chemistry/Chemical Pathology<br>• Blood Bank testing<br>• Immunology<br>• Microbiology<br>• Genetics (not related to inherited disease testing, or pre-natal and pregnancy testing)<br>• Point of care tests such as glucose, urinalysis, urine tests, rapid antigen tests etc.<br>For records of inherited disease testing see class 6.01. For records of pre-natal and pregnancy testing see 6.02.<br>Non-pathological (i.e. not requiring a sample or specimen from a patient's body) procedures and tests, include:<br>• radiology (X-Ray) images<br>• recordings of electroencephalograms (EEG), electrocardiograms (ECG), electromyograms (EMG), cardiotocograms (CTG) etc.<br>• ultra-sound images<br>• computed tomography (CT) scans<br>• magnetic resonance images (MRI)<br>• photographs | |

| | | |
|---|---|---|
| | • measurements, gradings, readings and other data.<br><br>**NOTE:** See **11.00** Patient and Client Information, for records documenting the evaluation and interpretation of results of pathological examinations performed for patient diagnosis.<br><br>**See** *Health Administration (DA2525) v2* 07.00 HEALTH CONDITION SCREENING (including Newborn) for records of health condition screening services<br><br>**See** Patient Information for records documenting the evaluation and interpretation of results of pathological examinations performed for patient diagnosis.<br><br>**See** *Police and Emergency Management (DA 2351)* 04.11.03 FORENSIC SERVICES for reports of forensic examination (autopsy/port-mortem reports) provided for the purposes of Coronial or criminal investigation | |
| **15.01** | **Requests**<br><br>Requests for diagnostic and testing procedures. | TEMPORARY<br><br>Destroy 1 year after action completed |
| **15.02** | **Pathology Specimens and Results**<br><br>Examined material, diagnostic recordings and laboratory results created in the process of diagnosing a patient.<br><br>Includes registers of tests and results. | TEMPORARY<br><br>Destroy after timeframes specified by standards and guidelines issued by the National Pathology Accreditation Advisory Council |
| **15.03** | **Non-pathological Test Results**<br><br>Records documenting results from a non-pathological diagnostic procedure. Includes images, readouts, completed worksheets, questionnaires or surveys.<br><br>Includes registers of tests. | TEMPORARY<br><br>Destroy 5 years after results delivered to requestor |
| **15.04** | **Non-Coronial Autopsy Services**<br><br>Investigations (diagnostic and testing) to determine or confirm the cause of death, or factors contributing to death.<br><br>Includes tissue and other samples taken for analysis.<br><br>Includes the development of reports and copies of notifications (where a cause or factor requiring notification under legislation is determined).<br><br>Includes registers or indices used to track and locate autopsy reports, notifications and any samples taken for analysis etc. | TEMPORARY<br><br>Destroy after timeframes specified by standards and guidelines issued by the National Pathology Accreditation Advisory Council |
| **16.00** | **Sexual Assault Forensic Examination Services** | |

| | | |
|---|---|---|
| | Clinical forensic examination services for patients who have experienced a recent sexual assault (in the last 7 days), and are seeking examination and evidence collection services for the potential purpose of pursuing criminal proceedings.<br><br>Includes referrals for counselling or support services.<br><br>Includes liaison with, and the provision of evidence and reports to, police or prosecution officers for the purposes of taking further action against an alleged perpetrator.<br><br>**Note**: Records of medical treatment and care services provided separately by the client's preferred medical services provider eg General Practitioner, hospital or health clinic are held separately to sexual assault forensic examination records.<br><br>**Note**: Sexual Assault Forensic Examination (SAFE) Services may only provide services to clients within a 7-day period following an assault as a core focus of the service is on examination and collection of forensic evidence for the purposes of criminal investigation and prosecution. After a 7-day period it is unlikely any reliable forensic evidence remains. Survivors who present after the 7-day period may be referred on to Sexual Assault Support Services (SASS) to seek counselling and support and/or medical treatment and care from their preferred medical practitioner. | |
| **16.01** | **Sexual Assault Forensic Examination Services Client Files**<br><br>Records of medical examination and support services given to sexual assault survivors, including:<br><br>• medical examination to ascertain type of sexual assault and injuries sustained<br>• evidence collection, eg forensic samples/swabs, blood tests, photographs, scans etc. Includes any referrals made for imaging services eg x-rays, or submission of samples for forensic testing etc.<br>• review of any other medical records that may be relevant to the assault or its immediate aftermath eg records of medical observations made/treatment provided by an ambulance crew or first responder<br>• documenting the results of examinations etc. in formal reports for use in criminal investigations/proceedings/prosecutions<br>• referrals to other support services, including counselling<br>• liaison with the police and/or public prosecution services<br>• liaison with support and advocacy services such as Victims of Crime etc. | TEMPORARY<br><br>Destroy 100 years after date of birth |