**44:79:08:03.  Record content.** Each medical record shall show the condition of the patient from the time of admission until discharge and shall include the following:

(1)  Identification data;

(2)  Consent forms, except when unobtainable;

(3)  History of the patient;

(4)  A current overall plan of care;

(5)  Report of the initial and periodic physical examinations, evaluations, and all plans of care with subsequent changes;

(6)  Diagnostic and therapeutic orders;

(7)  Progress notes from all disciplines;

(8)  Laboratory and radiology reports;

(9)  Description of treatments, diet, and services provided and medications administered;

(10)  All indications of an illness or an injury and change in condition, including the date, the time, and the action taken regarding each;

(11)  Advanced directive;

(12)  Physicians orders;

(13)  Patients' rights;

(14)  A final diagnosis;

(15)  A discharge summary; and

(16)  Discharge instructions for home care when applicable.

**Source:** 42 SDR 51, effective October 13, 2015.

**General Authority:** SDCL 34-12-13(10).

**Law Implemented:** SDCL 34-12-13(10).