**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).