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In its key document Good Medical Practice, the General Medical Council (GMC) states that in providing care the doctor must keep clear, accurate and legible records. 1 However, lack of awareness, indifference, habits or a combination of these result in deficient entries, leaving both the patient and the clinician at risk. This may be attributed to education on this subject being sporadic at best, although it is more often non-existent.

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Records must contain the following information: patient identification (i.e. name, address, contact numbers, personal health number, date of birth, emergency contact); for a consultation, the name and address of the primary care physician and of any health professional who referred the patient;

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You must be able to give patients a summary of their medical record. "They don't need the whole thing, because most patients have absolutely no idea what a medical record is, and what all it talks about," Searfoss notes. For EMRs, you want to provide the CCDA. This gives the pertinent information a patient expects for a medical record summary.

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