



STANDARDS OF PRACTICE

Patient Record Content

Under Review: ~~No~~Yes

Issued By: Council: January 1, 2010 (*Patient Records*)

Reissued by Council: July 1, 2011; January 1, 2016 (*Patient Record Content
and Patient Record Retention*)

The **Standards of Practice** of the College of Physicians & Surgeons of Alberta (“CPSA”) are the **minimum** standards of professional behavior and ethical conduct expected of all regulated members registered in Alberta. Standards of Practice are enforceable under the *Health Professions Act* and will be referenced in the management of complaints and in discipline hearings. CPSA also provides **Advice to the Profession** to support the implementation of the Standards of Practice.

The *Patient Records* standard was split into *Patient Record Content* and *Patient Record Retention* in January 2016.

Please refer to both [standards](#) [this](#) and the [Patient Record Content standard of practice](#) for [all the full](#) expectations related to patient records.

1. —A regulated member who provides assessment, advice and/or treatment to a patient **must**:
 - a. —document the encounter in a patient record (paper or electronic);
 - b. —ensure the patient record is:

PREAMBLE

Documentation of the care provided to patients is an essential component of safe and competent medical care.¹ The goal of the patient record is to “tell the story” of the patient’s health care **journey**; the patient record should be understandable for another healthcare provider to take over care of the patient if needed.¹ This includes avoiding the use of abbreviations that are known to have more than one meaning in a clinical setting or that are not commonly used or understood.³

This standard applies to all individuals registered with CPSA; all clinical encounters, whether patients are seen in-person or virtually; and to both paper and electronic medical records (EMRs).⁴

¹ From CPSM’s *Documentation in Patient Records Standard of Practice* (Feb. 2022), accessed Dec. 2025.

² From CPSO’s *Medical Records Documentation Policy* (Mar. 2020), accessed Dec. 2025.

³ From Health Quality Alberta’s (HQA) “*Hazards of Abbreviations, Symbols and Dose Designations*” (n.d.), accessed Dec. 2025.

⁴ From CPSNS’s *Charting Professional Standards and Guidelines* (Mar. 2023), accessed Dec. 2025.

Terms used in the Standards of Practice:

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Where this standard is more stringent than institutional requirements, the more stringent requirements of this standard must be followed; however, where this standard is less stringent, the institutional requirements must be followed.⁵

It is a professional obligation that regulated members are aware of, keep current with, and comply with the requirements of the *Health Information Act* (HIA) for the collection, use and disclosure of personal health information.⁶

Related standards, additional information and general advice can be found in the companion resources listed at the end of this document.

DEFINITIONS

Cumulative patient profile (CPP): a summary of essential information about a patient that includes critical elements of the patient’s medical history and allows the treating physician, and other healthcare providers using the medical record, to quickly get a picture of the patient’s overall health.⁷

Electronic medical records (EMR): a computer-based patient record that is created digitally or stored digitally (e.g., a paper record that has been scanned).^{6, 8}

Medical scribe: a person or organization that provides administrative support by documenting patient encounters in real time and may include gathering medical history, vital signs, prescription dosages, etc. This service can be done in person, virtually or off-site.

STANDARD

Documenting the encounter

1. A regulated member **must** create or contribute to a medical record for each patient they have assessed, treated or provided formal consultative service by:⁹
 - a. documenting the encounter in a patient record (paper or electronic); and

Commented [CD1]: From [CPSNL](#): added to clarify documentation is required of all regulated members, regardless of format.

⁵ From CPSNB’s *Patient Medical Records Professional Standards* (Apr. 2025), accessed Dec. 2025.

⁶ From CPSM’s *Documentation in Patient Records Standard of Practice* (Feb. 2022), accessed Dec. 2025.

⁷ From CPSO’s *Medical Records Documentation Policy* (Mar. 2020), accessed Dec. 2025.

⁸ From CPSNS’s *Charting Professional Standards and Guidelines* (Mar. 2023), accessed Dec. 2025.

⁹ From CPSNL’s *Medical Records Documentation & Management Standard of Practice* (Dec. 2023), accessed Dec. 2025.

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b. ensuring the patient record is:

i. completed as close in time as practicable to the patient interaction to promote accuracy¹⁰

ii. an accurate and complete and comprehensive reflection of the patient encounter to facilitate continuity in patient care;

iii. legible and in English;

iv. compliant with relevant legislation and institutional expectations; and

v. completed as soon as reasonable professional and non-discriminatory, in accordance with the Alberta Human Rights Act¹¹

2. A regulated member using a medical scribe must ensure:

a. a written agreement is in place that complies with the requirements of the HIA;

b. the medical scribe is appropriately trained and qualified to promote perform their duties;

c. medical scribe services comply with all relevant laws, legislation and professional standards related to confidentiality, privacy and data collection;

d. oversight of the work performed by the scribe and responsibility for the accuracy, completeness and timeliness of the services; and

e. that medical scribes do not perform tasks beyond their level of competence or engage in activities that constitute the unauthorized practice of medicine¹²

iv-3. A regulated member using artificial intelligence (AI) for the collection, transcription or analysis of patient data or to assist in clinical decision-making must ensure compliance with all relevant laws, legislation and professional standards related to confidentiality, privacy and data collection¹²

Commented [CD2]: From CPSNL: added to provide requested clarity (vs. current "as soon as reasonable").

Commented [CD3]: From CPSO: ensures entries that patients may see are appropriate.

Commented [CD4]: From CPSS: added for clarity.

Commented [CD5]: From CPSS: added for alignment with legislation, etc.

¹⁰ From CPSNL's *Medical Records Documentation & Management Standard of Practice* (Dec. 2023), accessed Dec. 2025.

¹¹ From CPSO's *Medical Records Documentation Policy* (Mar. 2020), accessed Dec. 2025.

¹² From CPSS's *Regulatory Bylaws: Part 6 – Practice Standards (23.1 Electronic Medical Records (EMRs))* (Jan. 2025), accessed Dec. 2025.

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2.4. A regulated member **must** ensure the patient record contains:

- a. an accurate and up to date CPP, contextual to the physician-patient relationship (i.e., the longer and more complex the relationship, the more extensive should be the record), detailing:
 - i. patient identification (e.g., name, date of birth, gender information), contact information (e.g., address, phone number, email address), personal health number, contact person in case of emergencies;
 - ii. the full name of the patient's substitute decision-maker or legal representative, if applicable;¹³
 - iii. personal and family data (e.g., occupation, life events, habits, family medical history);
 - iv. past and ongoing medical history (e.g., serious illnesses, operations, accidents, genetic factors, ongoing conditions, identified risk factors);
 - v. current medications and treatments, including complementary and alternative therapies;
 - vi. allergies and drug reactions;
 - vii. health maintenance plans (immunizations, disease surveillance, screening tests);
 - viii. date the CPP was last updated;
- b. clinical notes for each patient encounter, including:
 - i. the date;

Commented [CD6]: From CPSNL: consistent with other standards.

¹³ From CPSNL's *Medical Records Documentation & Management Standard of Practice (Dec. 2023)*, accessed Dec. 2025.

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a.1. ~~where the date of the encounter differs from the date of documentation, both dates must be recorded;~~^{14 15}

Commented [CD7]: From CPSM and CPSO: ensures a record of time differential if encounter not recorded on the same day.

ii. ~~presenting concern, relevant findings, assessment and history, assessment and appropriate focused examination, diagnosis and/or differential diagnosis, any treatment or therapy provided and management plan, including follow-up when indicated;~~^{15 16}

Commented [CD8]: From CPSO, CPSNS: added for clarity.

iii. ~~prescriptions issued, including drug name, dose, quantity prescribed, directions for use and refills issued;~~

iv. ~~tests, referrals and consultations requisitioned, including those accepted and declined by the patient; and a copy of the referral request and any associated reports or results;~~¹⁵

Commented [CD9]: From CPSO: added to ensure integrity of record.

v. ~~any treatments, investigations or referrals declined or deferred by the patient, including the reason given by the patient, if any, as well as the discussion of the risks;~~¹⁵

Commented [CD10]: From CPSO: expanded from current version (see (iv)) to ensure additional information is captured in record.

vi. ~~interactions with other databases, such as the Alberta Electronic Health Record (e.g., Netcare, Connect Care);~~

b.c. information pertaining to the [consent process](#);

c. ~~a cumulative patient profile (CPP) contextual to the physician-patient relationship (the longer and more complex the relationship the more extensive should be the record) detailing:~~

i. ~~patient identification (i.e., name, address, phone number, personal health number, contact person in case of emergencies);~~

ii. ~~current medications and treatments, including complementary and alternative therapies;~~

iii. ~~allergies and drug reactions;~~

¹⁴ From CPSM's *Documentation in Patient Records Standard of Practice* (Feb. 2022), accessed Dec. 2025.

¹⁵ From CPSO's *Medical Records Documentation Policy* (Mar. 2020), accessed Dec. 2025.

¹⁶ From CPSNS's *Charting Professional Standards and Guidelines* (Mar. 2023), accessed Dec. 2025.

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- iv. ~~ongoing health conditions and identified risk factors;~~
- v. ~~medical history, including family medical history;~~
- vi. ~~social history (e.g., occupation, life events, habits);~~
- vii. ~~health maintenance plans (immunizations, disease surveillance, screening tests); and~~
- viii. ~~date the CPP was last updated;~~
- d. laboratory, imaging, pathology and consultation reports;
- e. operative records, procedural records and discharge summaries;
- f. any communication with the patient concerning the patient's medical care, including unplanned face-to-face contacts; ~~(e.g., telephone, email, text messages, patient portals, etc.);~~^{17 18 19 20}
- g. a six-year history of patient ~~billing~~ encounter ~~billing~~ data, as required by Alberta Health (identifying type of service, date of service and fee(s) charged); and
- h. a record of missed and/or cancelled appointments.

Commented [CD11]: From CPSBC, CPSM, CPSO, and CPSPEI: ensures non-traditional encounters are captured in the record.

3.5. ~~Notwithstanding clause (2) a regulated member may indicate that the required documents are available in Netcare or other databasedatabases that can be reliably accessed for the length of time the record must be maintained.~~

4. ~~A regulated member may amend or correct a patient record in accordance with the Health Information Act (HIA) through an initialed and dated addendum or tracked change including the following circumstances:~~

6. ~~the correction~~A regulated member **must** avoid the use of abbreviations that are:

¹⁷ From CPSBC's Medical Record Documentation Practice Standard (May 2022), accessed Dec. 2025.

¹⁸ From CPSM's Documentation in Patient Records Standard of Practice (Feb. 2022), accessed Dec. 2025.

¹⁹ From CPSO's Medical Records Documentation Policy (Mar. 2020), accessed Dec. 2025.

²⁰ From CPSPEI's Charting Policy (Oct. 2025), accessed Dec. 2025.

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- a. unique to them so that they may be confusing or unknown to others;
- b. known to have more than one meaning in a clinical setting; or
- c. are otherwise not commonly used or an amendment is routine understood in nature, such as their area of practice.²¹

Commented [CD12]: From CPSNB: ensures accessibility and clarity for other healthcare providers/readers (e.g., the patient). Also aligns with [Health Quality Alberta's guidance](#).

Use of templates

7. If using templates, particularly those with pre-populated fields, within an electronic medical record, a change in name regulated member **must**:
- a. only use templates that allow encounters to be captured accurately and comprehensively (e.g., allow entry of free-text or content that can be customized to allow for greater descriptive detail); and
 - b. verify that entries populated using a template accurately reflect each encounter and that all pertinent details about the patient's health status have been captured.^{22 23 24 25}
8. A regulated member using templates **must not** copy and paste an entry related to a prior visit with a patient unless the copied entry is modified to remove outdated information; and includes current information.^{22 23 24 25}
- b. to ensure the accuracy of the information documented; or
 - c. at the request of a patient identifying incomplete or inaccurate information.

Commented [CD13]: From CPSM, CPSO, CPSPEI, and CPSS: added to ensure validity of information.

Notwithstanding (4c), a **Corrections to patient records**

Commented [CD14]: Moved below.

9. A regulated member who receives a written request from a patient to correct an error or omission or add additional information **must** consider the request in

²¹ From CPSNB's *Patient Medical Records Professional Standards* (Apr. 2025), accessed Dec. 2025.
²² From CPSM's *Documentation in Patient Records Standard of Practice* (Feb. 2022), accessed Dec. 2025.
²³ From CPSO's *Medical Records Documentation Policy* (Mar. 2020), accessed Dec. 2025.
²⁴ From CPSPEI's *Charting Policy* (Oct. 2025), accessed Dec. 2025.
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accordance with the HIA.

5.10. A regulated member **may** refuse to make a requested correction or amendment to a patient record in accordance with the HIA.

11. A regulated member **may** append additional information to **must not alter** a patient record after a complaint or legal action has been initiated unless a clinical fact is missing.

6.a. In this situation, a clear late entry to the record may be made in accordance with the HIA this standard.^{26 27}

Commented [CD15]: Combined with clause 7.

Commented [CD16]: Added based on current guidance.

Commented [CD17]: From CPSBC and [CPSNS](#): added for clarity – aligns with hearing tribunal decisions.

DRAFT

²⁶ From CPSBC's *Medical Record Documentation Practice Standard* (May 2022), accessed Dec. 2025.

²⁷ From CPSNS's *Charting Professional Standards and Guidelines* (Mar. 2023), accessed Dec. 2025.

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ACKNOWLEDGEMENTS

CPSA acknowledges the work of the Colleges of Physicians and Surgeons of... in preparing this document.

RELATED STANDARDS OF PRACTICE

- [Continuity of Care](#)
- [Episodic Care](#)
- [Establishing the Physician-Patient Relationship](#)
- [Informed Consent](#)
- [Non-Treating Medical Examinations](#)
- [Patient Record Retention](#)
- [Referral Consultation](#)
- [Virtual Care](#)

COMPANION RESOURCES

- Advice to the Profession:
 - [Continuity of Care](#)
 - [Episodic Care](#)
 - [Electronic Communications & Security of Mobile Devices](#)
 - [Establishing a Continuing Physician-Patient Relationship](#)
 - [Informed Consent for Adults](#)
 - [Informed Consent for Minors](#)
 - [Lost or Stolen Medical Records](#)
 - [Non-Treating Medical Examinations](#)
 - [Referral Consultation](#)
 - [Virtual Care](#)
- ~~[CMPA's Smartphone recordings by patients](#)~~
- ~~[CMPA's eLearning Modules](#)~~
- ~~[CMPA's Medical records articles](#)~~
- ~~[HQCA's Abbreviations in healthcare](#)~~
- ~~[OIPC's Communicating with Patients Electronically](#)~~
- ~~[CMPA:](#)~~
 - ~~[AI Scribes: Answers to frequently asked questions](#)~~

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- [Smartphone recordings by patients](#)
- [eLearning Modules](#)
- [My patients, my records?](#)
- [HQA's Hazards of Abbreviations, Symbols, and Dose Designations](#)
- [OIPC:](#)
 - [Communicating with Patients Electronically](#)
 - [OIPC's Guidelines for Managing Emails](#)

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