Records disposal schedule

Patient and Client Medical Records

Department of Health

Disposal Schedule No. 2022/003

August 2022

NORTHERN TERRITORY GOVERNMENT

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Preamble

Introduction

The *Information Act 2002* states that public sector organisations must safeguard their records and must not delete or otherwise dispose of a record unless authorised to do so[1]. Disposal of records is permitted through the use of records disposal schedules and enable regular, planned and authorised disposal of records controlled by an agency.

Records retention decisions are based on:

- the current and future business needs of the organisation
- compliance with legal and governance requirements of the organisation
- the current and future needs of internal and external stakeholders, including the wider community.

Records disposal schedules provide continuing authorisation for the legal disposal of records and are authorised by the records service, archives service and chief executive officer of the public sector organisation responsible for the schedule.

Records disposal schedules apply to records created and maintained in any format, including electronic records, records in business systems, and parts of records.

In the Northern Territory government there are two types of records disposal schedules:

- General records disposal schedules that apply to records common to most or all NT Government public sector organisations, and
- Functional records disposal schedules that apply to records specific to an NT Government public sector organisation or function.

Functional records disposal schedules should be used in conjunction with general records disposal schedules.

Structure of a Records Disposal Schedule

Records disposal schedules set out minimum requirements for the creation, maintenance, retention or destruction actions to be taken in relation to existing or future records described in each class. Records disposal schedules specify

a) whether a class of record has temporary or permanent status;
b) the retention period for a temporary class of record;
c) authorised disposal actions for a class of record. [2]

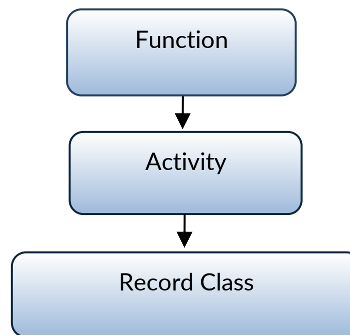
Each class of records created by an agency is described using classifications based on business analysis.

Disposal schedules are developed using the functional structure based on the classification scheme of the *Keyword AAA: A Thesaurus of General Terms* produced by the State Records Authority of NSW and modified for use by NT Government public sector organisations.

[1] S.145 Information Act 2002
[2] S.136A(3) Information Act 2002

Within the schedule, functions are documented as the highest level terms and business activities under the functions, followed by record classes, as shown in diagram 1.

Diagram 1



Function

The function or keyword is the highest level in the classification scheme in this disposal schedule. The function is indicated at the start of each section and a description (scope note) provided.

Activity

Activities are the processes or operations that make up the business function. This is the second level in the classification scheme in this disposal schedule. The description (scope note) provides details of the transactions that take place in relation to the activity, for example, REPORTING or POLICY.

Record class

A record class is a group of records that relate to the same activity, function or subject and require the same disposal action. The descriptions can relate to one record (such as a register) or a group of records documenting a particular set of business transactions.

Status and disposal action

The appraisal status of a record class is assigned as either permanent or temporary.

Permanent Records: Records appraised with permanent status have been identified as archives and must be transferred to the NT Archives Service for their preservation and eventual public access.

The retention period for permanent records is the maximum period before the records must be transferred to the Archives Service. Permanent records must be transferred no later than 30 years after creation in accordance with the Information Act 2002, unless exemption has been granted (see Archives Management Standards Transfer of Archives, and Exemption from Compulsory Transfer of Permanent Records to the NT Archives Service). An Application to Transfer Records form must be submitted to the Archives Service before records will be accepted for transfer.

Temporary records: The retention period for temporary records is the minimum period before the records can legally be destroyed. The retention period is calculated after an event or a disposal trigger such as 'date of action completed', 'date of audit' or 'date of birth'. Destruction should be done following consultation with relevant operational business employees responsible for the records.

Retention periods for temporary records in a records disposal schedule are minimum periods only and agencies may keep records for a longer period if considered necessary for business requirements.

Reasons for longer retention could include,

- administrative need or agency directives,
- legal requirements such as current or pending legal action,
- relevance to an investigation or inquiry which is in progress,
- is subject to an Information Access application, or
- subject to a disposal freeze.

Records created prior to 1 July 1978 must not be disposed of without the authorisation of the Archives Service in accordance with Archives Management Standard Records Created Prior to 1978, unless specified in a schedule.

Sentence records with this records disposal schedule using the following five steps:

1. Determine the appropriate function and activity of the records. This can be done by examining an existing record or when creating a new record.
2. Identify the disposal class.
3. From the disposal action in the class, identify the trigger event and a date when the record can be disposed of, alternately, identify that the record is to be retained permanently as archives.
4. If the trigger event has already occurred (such as action is completed), confirm and implement the disposal action.
5. If the trigger event has not occurred (e.g. the record is still in active use), set a review date for the future.

About this Records Disposal Schedule

Purpose

The purpose of this Records Disposal Schedule is to enable regular, planned and authorised disposal of Patient and Client medical records of the Department of Health.

Scope

Application of this Records Disposal Schedule is mandatory for Patient and Client medical records of the Department of Health.

This Records Disposal Schedule applies to Patient and Medical records in all formats.

1.1 Type of Records

Patient records, regardless of their format, must be sentenced in accordance with this schedule. Records relating to the provision of treatment and care to a patient include but are not limited to:

- Admission, including medical and nursing records
- History (medical and social of the patient or their family)
- Examination results (physical or other)
- Transfer, referral or assessment
- Correspondence between the patient or their representative and the health care service
- Consultation reports (medical or other)
- Principal diagnosis and any other significant diagnosis
- Medication or drug orders and medication administered or prescribed (including oral, parenteral, and incident reports)
- Nursing care plans and clinical pathway observations
- Counselling, allied health, social work or other health care professional notes
- Allergies or special conditions
- Doctor's or physician's orders
- All observations and progress notes
- Requests for diagnostic or investigative tests
- Results or reports of all laboratory, diagnostic or investigate tests or procedures performed (including pathology, X-ray or other medical imaging examinations)
- Consent or authority to carry out any treatment, procedure or release of information and certification that consent is informed (including removal or donation of tissue or organs, consent to special procedures, participate in research, etc)
- Refusal of treatment or withdrawal of consent
- Prenatal, obstetric, newborn and perinatal treatment, care and outcomes (includes newborn records and perinatal morbidity statistics)
- Surgical procedure or operation (including pre-operative checklists, anaesthetic records and peri operative nurses reports including instrument and swab count records and post-operative observations)
- All therapeutic treatments or procedures (including anti-coagulant, diabetic, dialysis, electric shock therapy (EST) and electro convulsive therapy (ECT)
- Statements made for the Police and Coronial Inquest reports
- Discharge (includes final diagnosis, operative procedures, summary or letter of discharge and discharge at own risk or against advice)

- Death (includes autopsy or post-mortem reports)
- Aerial Medical Services treatment and care records
- Telephone Triage notes

1.2 Digital Records

Born digital records and electronic records are subject to the provisions of this schedule in the same way as hard copy records, and are defined as records that are solely created, captured, recorded, stored and conveyed on a digital storage medium, such as a computer, and exist only in a digital format.

A digitised patient record is a record that has been transformed into a digital format from scanning a paper-based patient record. The source record is the systematic documentation of a single patient's medical history and includes, but is not limited to, notes captured at examination, treatment plans, medication charts, correspondence between treating clinicians and diagnostic reports. The digitised patient record is the scanned equivalent of the source record.

1.3 Retention of Records relating to Aboriginal people

All medical facilities and agencies must retain Aboriginal patient records for 100 years after their date of birth if their date of birth falls prior to and including 1975. This is a recommendation from the *1997 Australian Report of the National Inquiry into the Separation of Aboriginal and Torres Strait Islander Children from their Families, Bringing Them Home*. To identify and subsequently preserve the information on Aboriginal people, facilities are advised to consider the following:

- The Aboriginal status recorded on health information systems (eg: CCIS and PCIS)
- The record is of an individual with a recognised Aboriginal family name, including aliases
- The record relates to an individual of an identified Aboriginal community (eg Clinic records)
- The record relates to care delivered by a health service, including Mission, Station and itinerant health workers
- The record relates to a health program that provided care to the Aboriginal population (eg eye health)
- The record exists in an area with a high proportion of Aboriginal people such as the West and East Arnhem region, Victoria Daly River Region, West Daly Region, Roper Gulf region, Barkly Region, MacDonnell Region, Tiwi Islands and Central Desert Region
- The record contains evidence of adoption, fostering or an informal arrangement of care for a child

1.4 Date of last access

The retention period for most records is calculated or determined from the date of last access where the purpose of access is directly related to patient care, such as:

- Patient admission
- Non-admitted patient service, including emergency, outpatient, community health or community-based treatment programs.
- Records accessed under a subpoena or other medico-legal request

Date of access is not affected where the record is accessed for purposes not directly related to the care of the patient. Such as:

- Records accessed for education of health professionals
- Records accessed for research
- Records accessed for the provision of a report to another health care worker or agency
- Records accessed for the patient's next of kin
- Records retrieved for access under the *Information Act 2002*
- Records retrieved for post -discharge completion
- Records retrieved for general processing such as filing
- Records retrieved for clinical review, such as internal audits
- Records retrieved for the provision of copies of patient record documentation

1.5 Significance of records – Patient Samples

Those responsible for managing patient records should be alert to factors which may influence the business or historical value of records relating to patient and medical records. An individual patient record may be considered to be of business or historical value where it:

- Documents diagnoses that are controversial, new or rare
- Documents treatment or diagnostic interventions that are considered innovative or controversial
- Documents diagnoses and/or treatment that are attracting class action litigation
- Relates to matters that are attracting community wide interest
- Provides a comparative insight into the provision to particular community groups
- Provides comparative insight into aspects of treatment, care, and the delivery of services over time
- Documents significant achievements or break throughs in research or relate to research of major national or international significance, interest or controversy
- Document significant outbreaks of disease that represent/ed major public health risks and their impact
- Document critical points of change or developments in the treatment or management of a particular type of condition, illness or disease

Individual patient records that are selected, based on the factors outlined above, are considered to have been sampled. Sampled patient records (class 1.1.3) must be de-identified prior to transfer to the Archives Service. All permanent records are open for public access after 100 years in accordance with the Information Act (s. 142(4)).

Responsibility

The Chief Executive of the Department of Health is responsible for the content and implementation of this Records Disposal Schedule including the provision of advice and training, and for monitoring compliance.

Authority

This Records Disposal Schedule is authorised in accordance with s 136B of the *Information Act 2002*.

Disposal Schedule No. 2022/003 was approved by the Senior Director of Library & Archives NT (the Archives Service), Senior Director of Digital Policy and Data Strategy (the Records Service), and the Chief Executive of the Department of Health on 17 August 2022 and is effective immediately.

Re-sentencing records

All records sentenced under the following superseded records disposal schedules are to be re-sentenced using this schedule:

- Disposal Schedule for Patient Records of Northern Territory Public Hospitals and Community Health Services 2002/1
- Disposal Schedule for Hearing Services 2015/25 – Class 1.6.1,
- Disposal Schedule for Mental Health Services 2015/8 – Classes 1.4.1 – 1.4.2 – 1.4.3 – 1.4.4 – 1.4.5 & 1.4.6,
- Disposal Schedule for Volatile substance Abuse Prevention 2017/2 – Classes – 1.3.1 – 1.3.2 and 1.3.3,
- Disposal Schedule for Oral Health Services 2017/3 – Class 1.6.1
- Disposal Schedule for Alcohol and Other Drugs 2017/7 – Class 1.3.1

Regulatory framework

The regulatory basis for this Records Disposal Schedule is defined in:

- *Alcohol Harm Reduction Act 2017*
- *Cancer Registration Act 2009*
- *Coroners Act 1993*
- *Disability Services Act 1993*
- *Emergency Medical Operations Act 1973*
- *Health Legislation Amendment Act 2021*
- *Health Services Act 2014*
- *Medical Services Act 1982*
- *Mental Health and Related Services Act 1998*
- *Notifiable Diseases Act 1981*
- *Termination of Pregnancy Law Reform Act 2017*
- *Transplantation and Anatomy Act 1979*
- *Volatile Substance Abuse Prevention Act 2005*
- *Information Act 2002*
- NT Government Records Management Standards
- NT Government Archives Management Standards
- Australian Standards AS ISO 15489:Records Management.

Related documents

This Records Disposal Schedule is to be read in conjunction with:

- NT Public Sector Organisation Records and Information Management Standards
- policies and procedures of the Department of Health
- current authorised disposal schedules for the Department of Health
- current authorised general disposal schedules.

Normal administrative practice

Public sector organisations are permitted to dispose of some short term or ephemeral documents under the authority of the Disposal Schedule for Short Term Value Records. These include:

- duplicate (e.g. information or reference copy)
- obviously unimportant (e.g. telephone message slips)
- of short term facilitative value (e.g. compliment slips)
- a combination of these.

The guiding principle is that organisations should be sure that destroying these records will not destroy evidence that might be needed.

Records that have been captured into a recordkeeping system should be destroyed using the Disposal Schedule for Short Term Value Records unless the class of records has been identified in a specific disposal schedule.

Acknowledgement

The Archives Service and the Records Service acknowledge that material produced by National Archives of Australia, State Records Authority of New South Wales, State Records of South Australia, Public Records Office of Victoria, Territory Records Office and Standards Australia was used in the development of this schedule.

This work is copyright. Apart from any use as permitted under the Copyright Act 1968, no part may be reproduced by any process without prior written permission of the Archives Service. Requests and enquiries concerning reproduction and rights should be directed to the Director, Archives Service. The terms in the classification scheme are based on the Keyword AAA: A Thesaurus of General Terms (Government of New South Wales, 1998), and are produced under a licence agreement between the NT Archives Service and the State Records Authority of New South Wales.

Compliance checklist

Implement a records disposal program to ensure regular appraisal, sentencing, destruction and transfer of all records.	☐	Stop applying sentences from previous schedules that have been revoked or amended.	☐
Assign responsibility for the management and application of regular records disposal action using authorised records disposal schedules, to an appropriately skilled records manager who consults with the Archives Service and Records Service.	☐	Retain all records in good order and condition to be available for retrieval during the retention period.	☐
Identify and sentence all records described in this schedule in all formats including electronic records and records in business systems, copies of records and parts of records.	☐	Identify and update control records so that you can demonstrate what happened to each record, whether paper or electronic.	☐
Ensure all copies of temporary records are destroyed in any format (including backups), unless otherwise stated in a disposal schedule.	☐	Dispose of all records sentenced according to this schedule in all formats including electronic records and records in business systems, copies of records and parts of records.	☐
Apply this records disposal schedule to records in the organisation's records management systems, including systems for the management of paper records, electronic records, or records in any other format.	☐	Transfer records of permanent value to the Archives Service for retention as archives not later than 30 years after creation.	☐
Apply this records disposal schedule to records in the organisation's business systems, either directly or by linking the business system to a records management system.	☐	Inactive records can be transferred to offsite service providers providing they have been sentenced.	☐
Implement quality assurance mechanisms to periodically check that the disposal class originally assigned at the creation of the records is still applicable at the time of sentencing of the record.	☐	Destroy time expired temporary records in a secure manner that ensures complete deletion/destruction beyond any possible reconstruction.	☐
Implement review or quality control procedures in recordkeeping systems to ensure disposal actions are implemented correctly.	☐	Do not destroy records that are not described in an authorised records disposal schedule.	☐
Identify records that require re-sentencing where a previous disposal schedule has been superseded.	☐	Do not destroy any records created prior to 1 July 1978 without specific authorisation from the Archives Service.	☐

Disposal Schedule

1. Patient and Client Medical Records

The function of recording provided treatment and care services to patients across the Northern Territory, including patients treated in hospitals, primary care facilities, community care centres and other public medical facilities.

1.1 Clinical Information

The activities associated with medical clinical care to individual patients and clients, including specialist categories such as cancer, mental health, obstetrics, assisted reproductive technology, sexual assault, organ and tissue donations, sexual reassignment, blood and blood product transfusion, tuberculosis and dentist specialist.

Class No.	Subject	Description of Records	Status and Disposal Action
1.1.1	Clinical Research – gene therapy (including clinical trials)	Records documenting the conduct of clinical trials and experiments on patients that involve gene therapy, including work that has community, cultural or historical value. Includes consent forms, approvals, medical assessments, diagnostic reports, treatment plans, laboratory results, questionnaires, clinical surveys, reports, research data and other supporting documentation.	PERMANENT Transfer to Archives Service 10 years after action completed
1.1.2	Clinical Research (including clinical trials)	Records documenting the conduct of clinical trials and experiments that do not involve gene therapy or work that has community, cultural or historical value. Includes consent forms, approvals, medical assessments, diagnostic reports, treatment plans, laboratory results, questionnaires, clinical surveys, reports, research data and other supporting documentation.	TEMPORARY Destroy 15 years after last access

Note: All entries apply to records in any format, including electronic media, unless otherwise specified. It is the responsibility of all public sector organisations to ensure that all records are readily accessible for the retention periods specified.
Records relating to Aboriginal patients and clients born prior to 1975 must be retained for 100 years after date of birth.
Patient and Client medical records dated prior to the 1 July 1978 are further assessed by the Archives Service.

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Class No.	Subject	Description of Records	Status and Disposal Action
1.1.3	Patient Samples	Samples of patient records identified as being of continuing value for medical or social research purposes. NOTE: Refer to 1.5 Significance of records – Patient Samples.	PERMANENT Transfer to Archives Service 10 years after action completed
1.1.4	Dentist – Specialist	Records documenting the provision of specialist orthodontics dental services to individual patients that are both adult and minors, including patients who are medically compromised such as those with HIV/AIS, Hepatitis C, Tuberculosis, or who have complex medical problems including those who have complex medication requirements that affect their ability to receive dental treatment such as medications for treatment of cancer, medications for blood thinning etc. Includes: progress notes, pathology reports and results, laboratory forms, referral correspondence, assessment forms, care plans, teeth charts and dental case notes.	TEMPORARY Destroy 100 years after patient's date of birth
1.1.5	Dentist – general	Records documenting the examination, assessment and treatment of dental patients and clients, including minors. Includes dental charts, consent forms and x-rays.	TEMPORARY Destroy 15 years after last access or 45 years after date

Note: All entries apply to records in any format, including electronic media, unless otherwise specified. It is the responsibility of all public sector organisations to ensure that all records are readily accessible for the retention periods specified.
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Class No.	Subject	Description of Records	Status and Disposal Action
			of birth where the patient is a minor, whichever is the latest
1.1.6	Records relating to Aboriginal People	Records documenting individual patient records relating to the treatment and care of Aboriginal people born prior to and including 1975. NOTE: Refer to 1.3 in the preamble – Retention of Records relating to Aboriginal people.	TEMPORARY Destroy 100 years after patient's date of birth
1.1.7	Tuberculosis Leprosy	Records documenting individual patient records relating to the treatment for both infectious diseases, tuberculosis and leprosy. Includes: medical assessments, radiographic films, progress notes and treatment notes.	TEMPORARY Destroy 100 years after patient's date of birth
1.1.8	HIV	Records documenting individual patient records relating to the treatment and care for HIV (human immunodeficiency virus).	TEMPORARY Destroy 100 years after patient's date of birth

Note: All entries apply to records in any format, including electronic media, unless otherwise specified. It is the responsibility of all public sector organisations to ensure that all records are readily accessible for the retention periods specified.
Records relating to Aboriginal patients and clients born prior to 1975 must be retained for 100 years after date of birth.
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Class No.	Subject	Description of Records	Status and Disposal Action
1.1.9	Genetic Testing	Records documenting genetic testing on patients for the purpose of genetic diagnosis of vulnerabilities to inherited diseases by a clinical geneticist. Includes: investigations reports, medical reports, counselling records, genetic test results and medical care and treatment records, cryopreservation records, blood and bone marrow slides, Guthrie cards test, follow up forms, molecular genetics data, photographic film strips, request forms, tissue samples, workbooks, clinical genetics data, family/pedigree charts and referral letters.	TEMPORARY Destroy 100 years after last access
1.1.10	Cancer Care/ Neoplasms	Records documenting the care and treatment of patients diagnosed with cancer. Includes: referrals, admission forms, consent forms, cytotoxic medication orders, drug charts, histopathology reports, laboratory test results, medical imaging, progress notes, summaries, worksheets.	TEMPORARY Destroy 15 years after death of patient, or 100 years after date of birth if date of death is unknown

Note: All entries apply to records in any format, including electronic media, unless otherwise specified. It is the responsibility of all public sector organisations to ensure that all records are readily accessible for the retention periods specified.
Records relating to Aboriginal patients and clients born prior to 1975 must be retained for 100 years after date of birth.
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Class No.	Subject	Description of Records	Status and Disposal Action
1.1.11	Blood and Blood Product Transfusion	Records documenting individual patient records where treatment included blood transfusion or the receipt of blood product. Includes consent forms and blood transfusion records. May include management of adverse events.	TEMPORARY Destroy 15 years after death of patient, or 100 years after date of birth if date of death is unknown
1.1.12	Assisted Reproductive Technology (ART)	Records documenting Assisted Reproductive Technology where a pregnancy is achieved. Includes individual case records. Includes individual case records and consent forms for in-vitro fertilisation, artificial insemination and use of semen, ova or embryos.	Temporary Destroy 75 years after date of insemination
1.1.13	Assisted Reproductive Technology (ART)	Records documenting Assisted Reproductive Technology where a pregnancy was not achieved, or the procedure was terminated.	TEMPORARY Destroy 15 years after last access

Note: All entries apply to records in any format, including electronic media, unless otherwise specified. It is the responsibility of all public sector organisations to ensure that all records are readily accessible for the retention periods specified.
Records relating to Aboriginal patients and clients born prior to 1975 must be retained for 100 years after date of birth.
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Class No.	**Subject**	**Description of Records**	**Status and Disposal Action**
		Includes individual case records and consent forms for in-vitro fertilisation, artificial insemination and use of semen, ova or embryos. May include withdrawal of consent.	
1.1.14	Sexual Health Clinic	Records documenting individual patient records relating to the treatment and care of sexually transmissible infections and blood borne viruses. Excludes: Records documenting the treatment and care of patients with HIV (Human Immunodeficiency Virus).	TEMPORARY Destroy 50 years after last access
1.1.15	Organ and Tissue Donation	Records documenting the donation of organs and/or tissues via a surgical procedure of either a living or deceased person as required under the *Transplantation and Anatomy Act 1979*.	TEMPORARY Destroy 50 years after last access (applies to adults and minors)

Note: All entries apply to records in any format, including electronic media, unless otherwise specified. It is the responsibility of all public sector organisations to ensure that all records are readily accessible for the retention periods specified.
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Class No.	Subject	Description of Records	Status and Disposal Action
		Includes: local copies of DonateLife records and consent forms, advanced consent forms under registered advanced personal plans, consent given by the Coroner under the *Coroners' Act* and medical certificates.	
1.1.16	Alcohol and Other Drugs	Records documenting the assessment and / or treatment of persons admitted to a treatment facility as required under the *Alcohol Harm Reduction Act 2017*, including variations and revocations. Includes: assessment reports, nomination of primary persons, notice of hearings, Tribunal orders, income management orders, treatment plans and aftercare treatment plans. May include requests for services, including requests to see a community visitor and related correspondence.	TEMPORARY Destroy 50 years after last access
1.1.17	Volatile Substance Abuse	Records documenting clinical services provided to persons who have been mandated for treatment under the *Volatile Substance Abuse Prevention Act 2005* where they have been assessed as being at risk of severe harm.	TEMPORARY Destroy 50 years after date of last access

Note: All entries apply to records in any format, including electronic media, unless otherwise specified. It is the responsibility of all public sector organisations to ensure that all records are readily accessible for the retention periods specified.
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Class No.	Subject	Description of Records	Status and Disposal Action
		Includes memoranda, assessment reports, recommendations for treatment, letters to referrers, clinicians' assessments, treatment orders, affidavits, warrants and other related correspondence. May include records where the assessor makes an assessment where treatment is not recommended or where the assessor makes a decision not to make an assessment of persons.	
1.1.18	Mental Health – Involuntary and Voluntary Admissions	Records documenting involuntary and voluntary admission of persons including prisoners, to an approved treatment facility or a hospital, or in the community under the Mental Health and Related Services Act 1998. Includes: recommendations, request for psychiatric examination, notifications, review and progress notes and reports, treatments management plans, discharge forms and plans. May include written reports to the Tribunal, community management orders, notifications to the principal community visitor or Tribunal, Tribunal court orders, appointments of psychiatric case manager, leave of absence certificates, and financial protection orders.	TEMPORARY Destroy 50 years after date of last access

Note: All entries apply to records in any format, including electronic media, unless otherwise specified. It is the responsibility of all public sector organisations to ensure that all records are readily accessible for the retention periods specified.
Records relating to Aboriginal patients and clients born prior to 1975 must be retained for 100 years after date of birth.
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Class No.	Subject	Description of Records	Status and Disposal Action
		May also include intergovernmental agreements for individuals with the Minister of another state or Territory and copies of interstate transfer orders approved by the CEO, non-custodian orders and dismissal of charge reports to the Court from the Chief Health Officer and other supporting medical profession reports.	
1.1.19	Mental Health – Refused Voluntary Admission	Records documenting persons who apply to be admitted to an approved treatment facility as a voluntary patient who have been refused by a medical practitioner or psychiatric practitioner in accordance with the *Mental Health and Related Services Act* 1998. Includes: consents, examination notes and decisions with explanations of the grounds for decision, may also include requests for assessment of persons for the purpose of determining whether the declined person is in need of treatment under the *Mental Health and Related Services Act* 1998.	TEMPORARY Destroy 15 years after last access or 45 years after date of birth where the patient is a minor, whichever is the latest

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1. Patient and Client Medical Records

The function of recording provided treatment and care services to patients across the Northern Territory, including patients treated in hospitals, primary care facilities, community care centres and other public medical facilities.

1.1 Clinical Information

The activities associated with medical clinical care to individual patients and clients, including specialist categories such as cancer, mental health, obstetrics, assisted reproductive technology, sexual assault, organ and tissue donations, sexual reassignment, blood and blood product transfusion, tuberculosis and dentist specialist.

Class No.	Subject	Description of Records	Status and Disposal Action
		May include requests for assessment of persons for the purpose of determining whether he or she or another person, is in need of treatment under the *Mental Health and Related Services Act 1998* has been declined.	
1.1.20	Sexual Assault - Minors	Records documenting patients under 18 years old that are considered minors who have been sexually assaulted. Includes assessment reports, photographs, treatment, and care provided, medico-legal reports, referrals for counselling and results from drug screening where drink spiking is suspected.	TEMPORARY Destroy 75 years after date of birth
1.1.21	Sexual Assault - Adults	Records documenting persons who have been sexually assaulted, including other vulnerable persons such as elderly, disabled or persons in care subject to mandatory reporting. Includes assessment reports, photographs, treatment, and care provided, medico-legal reports, referrals for counselling and results from drug screening where drink spiking is suspected.	TEMPORARY Destroy 50 years after last access

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Class No.	Subject	Description of Records	Status and Disposal Action
1.1.22	Obstetrics	Records documenting obstetrics care provided at hospitals, antenatal clinics, post-natal clinics, obstetric or birthing wards or any other inpatient, outpatient or emergency care. May include clinical records of the mother and of the child. Includes: antenatal or prenatal treatment, apgar scores, CTG findings, delivery data, epidural forms, hepoximeter printouts, newborn records, obstetric records (mother's record), perinatal morbidity statistics, postnatal domiciliary visit referrals, postnatal feeding, foetal growth, progress of labour and clinical or client related records. Excludes: Records relating to artificial insemination or in-vitro fertilisation (IVF) procedures.	TEMPORARY Destroy 50 years after last access
1.1.23	Infectious Disease	Records documenting infectious disease outbreaks where there is a coordinated public health response such as acute rheumatic fever cases, invasive group A streptococcal, rotavirus, measles and melioidosis. Includes data collection forms, questionnaires, laboratory results, advice to General Practitioners, and related contact tracing documents.	Temporary Destroy 15 years after action completed

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Class No.	Subject	Description of Records	Status and Disposal Action
1.1.24	Notifiable Disease Reports	Notification of disease reports where there is an obligation to report to the Centre for Disease Control. Excludes: Notifications of STI's for patients under 14 years of age.	Temporary Destroy 24 months after Notifiable Disease register has been updated
1.1.25	Notifiable Disease Reports	Notification of disease reports where an STI is detected in patients under 14 years of age. Includes copy of pathology reports and written notification reports to Child Protection Authorities.	TEMPORARY Destroy 45 years after patient's date of birth or 7 years after last access
1.1.26	Unborn Child at Risk	Records documenting unborn child at risk notifications received by health facilities and child protection authorities where an unborn child may be at risk of harm, including where the patient does not present at the health facility for delivery.	TEMPORARY Destroy 45 years after date of birth or 15 years after last access whichever is the later

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Class No.	**Subject**	**Description of Records**	**Status and Disposal Action**
1.1.27	Disability	Records documenting the medical treatment and care of patients under a legal disability. Includes medical assessments, medical treatment and consultation notes, copies of community treatment orders, individual service plans, legal orders, mobile support and treatment records.	TEMPORARY Destroy 50 years after last access
1.1.28	Implants	Records documenting implants into the body, including significant biomedical or artificial material, devices or prostheses via a surgical procedure, including biomedical engineering, re-implants and removals and temporary implants.	TEMPORARY Destroy 50 years after last access
1.1.29	General Care - Adult	Records documenting patient treatment and care history provided to; • Acute Hospital Patients • Outpatients • Community Care Patients • Primary Health Care Patients • Emergency Patients • Allied Health Patients	TEMPORARY Destroy 15 years from date of last access or date of death

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Class No.	Subject	Description of Records	Status and Disposal Action
		Excludes: records for patients receiving treatment for cancer, mental health, tuberculosis, leprosy, sexually transmissible infections, infectious diseases, obstetrics, assisted reproductive technology, sexual assault, organ donations, gender identity disorder, sexual reassignment, genetic testing, implants, legal disability, alcohol and other drugs, blood and blood product transfusion, dental specialists, including immigration detainees, temporary clients or tourists, patients subject to clinical research trials and unborn children declared at risk.	
1.1.30	General Care - Minor	Records documenting patient treatment and care history provided to; • Acute Hospital Patients • Outpatients • Community Care Patients • Primary Health Care Patients • Emergency Patients • Allied Health Patients	TEMPORARY Destroy 45 years after date of birth or 15 years after last access, whichever is the latest

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Class No.	Subject	Description of Records	Status and Disposal Action
		Excludes: records for patients receiving treatment for cancer, mental health, tuberculosis, leprosy, sexually transmissible infections, infectious diseases, obstetrics, assisted reproductive technology, sexual assault, organ donations, gender identity disorder, sexual reassignment, genetic testing, implants, legal disability, alcohol and other drugs, blook and blood product transfusion, dental specialists, including immigration detainees, temporary clients or tourists, patients subject to clinical research trials and unborn children declared at risk.	
1.1.31	Community Health	Records documenting the provision of treatment, care, assessment, screening and other services to community clients, including patients who are deemed visitors. Includes: immunisations and vaccination records, audiology and eyesight screenings, breast screening and other imaging services, child health checks, family health and school health screening checks, antenatal and perinatal checks.	TEMPORARY Destroy 15 years after last access or 45 years after date of birth where the patient is a minor, whichever is the latest

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Class No.	Subject	Description of Records	Status and Disposal Action
1.1.32	Hearing Assessments	Records documenting hearing assessments on adults, children and infants. Includes comprehensive diagnostic hearing services and special diagnostic testing. Includes referrals, assessment notes, audiology data and other supporting documentation. May include referrals to the Department of Education for hearing advisory support and Australian Hearing for rehabilitation.	TEMPORARY Destroy 15 years after last access or 45 years after date of birth where the patient is a minor, whichever is the latest
1.1.33	Immigration Detainee	Records documenting the medical treatment and care provided to patients that are deemed unlawful non-citizens by national immigration legislation. Includes: medical assessments, consultation and treatment records, dental and psychological records, medical test results, medical reports and related correspondence.	TEMPORARY Destroy 15 years after last access
1.1.34	Temporary Client Cards/Tourist Cards	Records documenting individual patient records for residents and non-residents of the Northern Territory who receive 3 or less occasions of care by a health service and have declared they are not staying in the Northern Territory for longer than 6 months.	TEMPORARY Destroy 15 years after last access or 45 years after date

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Class No.	Subject	Description of Records	Status and Disposal Action
			of birth where the patient is a minor, whichever is the latest

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