



**A Clinician's Guide to Record Standards – Part 2:**  
Standards for the structure and content  
of medical records and communications  
when patients are admitted to hospital

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Royal College  
of Physicians

Setting higher medical standards

Developed by the Health Informatics Unit,  
Clinical Standards Department, Royal College of Physicians

**NHS**

**Connecting for Health**

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# Introduction

These standards were developed by the Health Informatics Unit, Royal College of Physicians, in a project supported by funding from NHS Connecting for Health. The standards for the structure and content of medical records were developed in collaboration with the other medical Royal Colleges and specialist societies. They were approved by the Academy of Medical Royal Colleges on 17th April 2008.

Please refer to the related publication “A Clinician’s Guide to Record Standards – Part 1: Why standardise the structure and content of medical records?” for more information about the project.

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# Section one

## RCP Approved 'Generic Medical Record Keeping Standards'

Prepared by the Health Informatics Unit of the Royal College of Physicians

Generic medical record keeping standards define good practice for medical records and address the broad requirements that apply to all clinical note keeping. These standards were developed by the Health Informatics Unit of the Royal College of Physicians following review of published standards and wide consultation. They were first published in 2007 in Clinical Medicine.

Standard	Description
1	The patient's complete medical record should be available at all times during their stay in hospital.
2	Every page in the medical record should include the patient's name, identification number (NHS number <sup>1</sup> ) and location in the hospital.
3	The contents of the medical record should have a standardised structure and layout.
4	Documentation within the medical record should reflect the continuum of patient care and should be viewable in chronological order.
5	Data recorded or communicated on admission, handover and discharge should be recorded using a standardised proforma <sup>2</sup> .
6	Every entry in the medical record should be dated, timed (24 hour clock), legible and signed by the person making the entry. The name and designation of the person making the entry should be legibly printed against their signature. Deletions and alterations should be countersigned.
7	Entries to the medical record should be made as soon as possible after the event to be documented (e.g. change in clinical state, ward round, investigation) and before the relevant staff member goes off duty. If there is a delay, the time of the event and the delay should be recorded.
8	Every entry in the medical record should identify the most senior healthcare professional present (who is responsible for decision making) at the time the entry is made.
9	On each occasion the consultant responsible for the patient's care changes, the name of the new responsible consultant and the date and time of the agreed transfer of care, should be recorded.
10	An entry should be made in the medical record whenever a patient is seen by a doctor. When there is no entry in the hospital record for more than four (4) days for acute medical care or seven (7) days for long-stay continuing care, the next entry should explain why <sup>3</sup> .
11	The discharge record/discharge summary should be commenced at the time a patient is admitted to hospital.
12	Advance Decisions to Refuse Treatment, Consent, Cardio-Pulmonary Resuscitation decisions must be clearly recorded in the medical record. In circumstances where the patient is not the decision maker, that person should be identified e.g. Lasting Power of Attorney.

<sup>1</sup> The NHS number is being introduced as the required patient identifier.

<sup>2</sup> This standard is not intended to mean that a handover proforma should be used for every handover of every patient rather than any patient handover information should have a standardised structure.

<sup>3</sup> The maximum interval between entries in the record would in normal circumstances be one (1) day or less. The maximum interval that would cover a bank holiday weekend, however, should be four (4) days.

# Section two

## Hospital admission record: headings and definitions

The headings presented here are ‘anchor’ points for the clinical information in the admission record. The detail and specialty specific requirements under each heading will be refined in work to follow. Not all headings are relevant in paper records nor on all occasions. In the electronic environment some of the headings will be automatically completed.

An example of a recommended paper proforma can be found in the Royal College of Physicians templates online at <http://www.rcplondon.ac.uk/hiu>

Headings/sub-headings	Definition/illustrative description of the type of clinical information to be recorded under each heading
Responsible consultant	The name of the consultant physician who will be responsible for the patient’s inpatient care.
Clerking doctor	The full name, grade and contact details of the doctor recording the clinical information contained in the admission clerking. GMC Number (unique identifier). Identify chaperone eg offered, present or not, name etc.
Source of referral	A record of the healthcare setting from which the patient was referred for hospital admission, e.g. GP, accident and emergency etc.
Time and date patient seen	The time and date the patient was assessed by the clerking doctor.
Time and date of clerking	The time and date the clerking doctor writes the record of the admission clerking.
Patient’s location	The physical location where the patient was assessed, specifying bay and bed when possible.
Reason for admission and Presenting complaints	The health problems and issues experienced by the patient resulting in their referral by a healthcare professional for hospital admission, e.g. chest pain, blackout, fall, a specific procedure, investigation or treatment.

Headings/sub-headings	Definition/illustrative description of the type of clinical information to be recorded under each heading
History of each presenting complaint	The record of clinical information directly related to the development and characteristics of each presenting complaint.
Past medical, surgical and mental health history	The record of the patient's previous diagnoses, problems and issues, procedures, investigations, adverse anaesthetic events etc.
<b>Medication record</b>	
- Current medications	The record of medications, dietary supplements, dressings and equipment that the patient is currently taking or using, eg prescribed medications, over-the-counter preparations, medications obtained from other sources etc.
- Relevant previous medications	The record of medications, dietary supplements, dressings and equipment that the patient has taken or has used, relevant to their presentation, e.g. prescribed medications, over-the-counter preparations, medications obtained from other sources etc.
<b>Relevant legal information</b>	
- Mental capacity	The mental capacity of the patient to make decisions about treatment etc. Example, where an Independent Mental Capacity Advocate (IMCA) is required for decisions relating to discharge destination, medical treatment, ability to consent etc. Who is the patient's advocate?
- Advance decisions to refuse treatment	Written documents, completed and signed when a person is legally competent, that explain a person's medical wishes in advance, allowing someone else to make treatment decisions on his or her behalf later in the disease process.
- Lasting power of attorney or deputy	If there is a lasting power of attorney, who is this person or their deputy.
- Organ donation	Has the person given consent for organ donation.

<b>Allergies and Adverse reactions</b>	Allergies, drug allergies and adverse reactions.
<b>Risks and warnings</b>	Significant risk of an unfavourable event occurring, patient is Hepatitis C +ve, MRSA +ve, HIV +ve etc. Any clinical alerts, risk of self neglect/aggression/exploitation by others.
<b>Social history</b>	
- Lifestyle	The record of lifestyle choices made by the patient which are pertinent to his or her health or social care. Example the record of the patient's current and previous use of tobacco products, alcohol, recreational drugs pets, hobbies, sexual habits, menstrual and coital history.
- Social and personal circumstances	The record of a patient's social background, network and personal circumstances, e.g. occupational history, housing and religious, ethnic and spiritual needs.
- Services and carers	The description of services and carers provided for the patient to support their health and social wellbeing.
<b>Family history</b>	The record of relevant illness in family relations deemed to be significant to the care or health of the patient, including mental illness and suicide.
<b>Systems enquiry</b>	The record of clinical information gathered in response to questions to the patient about general symptoms from various physiological systems, including food intake (increasing/decreasing), weight change, swallowing difficulties. Mood/anxiety etc.
<b>Patient's concerns, expectations and wishes</b>	The record of the patient's comments related to their perceptions of their symptoms, their wishes and goals related to their health and their perceptions of their anticipated treatment (which may influence treatment). This could be the carer giving information if the patient is not competent. Also the extent to which the patient wants clinical information to be shared with relatives and others.
<b>Observations and findings</b>	Any clinical observation or finding made by the clerking doctor, with or without specific clinical examination.

Headings/sub-headings	Definition/illustrative description of the type of clinical information to be recorded under each heading
- General appearance	The record of a doctor's 'end of the bed' assessment including general clinical examination findings, eg clubbing, anaemia, jaundice, obese/malnourished/cachectic, height, weight etc.
- Structured scales	e.g. Glasgow Coma Scale, ADL scales such as Barthel, nutrition screening scale etc.
- Vital signs	The record of essential physiological measurements, eg respiration rate, O <sub>2</sub> saturation, heart rate, blood pressure, temperature and weight, Early Warning Score (EWS), including the time and date they were obtained.
- Mental state	e.g. Depression, anxiety, confusion, delirium.
- Cardiovascular system	The record of findings from the cardiovascular system examination.
- Respiratory system	The record of findings from the respiratory system examination.
- Abdomen	The record of findings from the abdominal examination.
- Genito-urinary	The record of findings from the genito-urinary examination.
- Nervous system	The record of findings from the nervous system examination.
- Musculoskeletal system	The record of findings from the musculoskeletal system examination.
- Skin	The record of findings from examination of the skin.
<b>Problem list and/or Differential diagnosis</b>	Summary of problems that require investigation or treatment.
<b>Relevant risk factors</b>	Factors that have been shown to be associated with the development of a medical condition being considered as a diagnosis/ differential diagnosis. Thrombo-prophylaxis.

<b>Discharge planning</b>	Information in relation to discharge planning should be entered here, starting at the time of admission.
<b>Management plan</b>	Overall assessment and actions.
- Summary and interpretation of findings	Summary and interpretation of findings.
- Next steps	Next steps.
- Special monitoring required	e.g. neuro-obs, O2 saturation etc.
- Resuscitation status	Resuscitation status.
- Information given to the patient and/or authorised representative	<p>This can include:</p> <ul style="list-style-type: none"> <li>• relatives and carers</li> <li>• specific verbal advice and details of any discussions</li> <li>• written information including leaflets, letters and any other documentation.</li> </ul> <p>Differentiation required between information given to patients, carers and any other authorised representatives.</p>
<b>Investigations and initial procedures</b>	The results and/or interpretation of results of investigations and procedures. Planned procedures.
<b>Person completing clerking</b>	
- Doctor's name	
- Grade	
- Doctor's signature	
<b>Specialist registrar/senior review</b>	Where an admission clerking is reviewed by a specialist registrar or other senior doctor.
<b>Post take ward round</b>	Where a history and initial results are reviewed, clinical decisions are made, a management plan is formulated, and further investigations planned.

# Section three

## Handover documents: headings and definitions

Handover of patient care from one professional or team to another is one of the very high risk transactions of health care services.

Paper handover documents will be used in many cases until fully electronic systems are in routine practice. Paper documents should use a subset of these headings to ensure that patient critical information is conveyed while minimizing the risks associated with completing long paper forms.

There are several types of handover including hospital at night, weekend and consultant team to consultant team. Each type of handover may use a different subset of the headings. Suggested headings for paper transactions are illustrated in the table on pages 14 and 15. Examples of recommended documents can be found in the Royal College of Physicians templates online at <http://www.rcplondon.ac.uk/hiu>

Headings/sub-headings	Definition/illustrative description of the type of clinical information to be recorded under each heading
<b>Date</b>	The date of creation of the handover document.
<b>Time</b>	The time of creation of the handover document.
<b>Patient details</b>	
- Patient surname, forename	
- Date of birth	
- NHS Number	
- Gender	
- Current location	This could be a ward or theatre.
- Intended location	If patient is changing ward.
<b>Clinical details</b>	
- Date of admission	
- Expected date of discharge	The date the patient is currently expected to be discharged from hospital.

- Responsible consultant	The name of the consultant who is currently responsible for the patient's inpatient care.
- New responsible consultant	The name of the consultant who is accepting responsibility for the patient's inpatient care.
- Diagnosis/ problem list/ differential diagnosis	This would include working diagnoses or differential diagnoses. This could include multiple entries. Relevant previous medical history.
- Mental capacity	The mental capacity of the patient to make decisions about treatment etc. Example, where an Independent Mental Capacity Advocate (IMCA) is required for decisions relating to discharge destination, medical treatment, ability to consent etc. Any information given to a significant other in relation to this matter.
- Advance decisions to refuse treatment and Resuscitation status	Whether or not there is Do Not Resuscitate or Advance Decisions to refuse treatment information in the notes.
- Mental state	e.g. Depression, anxiety, confusion, delirium.
- Patient at high risk	This patient is at high risk of deterioration and will need an immediate response if called.
- Allergies	Allergies, drug allergies and adverse reactions.
- Risks and warnings	Can include: indication of severity of illness; religion, e.g. Jehovah's Witness; early warning scores, vital signs, seriously abnormal pathology results, patient with particular needs, any clinical alerts.
<b>Reason for handover</b>	Clinical reason, e.g. low potassium, immediately post-op, unstable medical condition.
<b>Management plan</b>	
- Clinical narrative (consultant to consultant team handover only)	Very brief narrative description of the in-patient episode.
- Current treatment/ Investigations	Treatments (inc referrals) carried out including investigation results awaited or planned. Recent operations including post-op instructions. Succinct information.

Headings/sub-headings	Definition/illustrative description of the type of clinical information to be recorded under each heading
- Aims and limitations of treatment and special instructions	The current aim of treatment including limitations to treatment and communication issues, e.g. not for ITU.
- Escalation plan	Who needs to be contacted in the event of significant problems or patient deterioration include, e.g. seniority/name/contact details of person to be called.
- Agreed with patient or legitimate patient representative (Y/N)	Can include: treatment, expected outcomes, risks and alternative treatments if any.
<b>Outstanding issues</b>	
- Tasks which must be done	Include timescales. (Appropriate seniority of staff for each task).
- Tasks to be done if possible	(e.g. test review, pre-discharge documents) criteria for discharge including who may discharge the patient.
- Information given to patient and/or authorised representatives	<p>This can include:</p> <ul style="list-style-type: none"> <li>• relatives and carers</li> <li>• specific verbal advice and details of any discussion</li> <li>• written information including leaflets, letters and any other documentation.</li> </ul> <p>Differentiation required between information given to patients and carers and any other authorised representatives.</p>
<b>Doctor handing over</b>	
- Name	
- Grade	
- Specialty	
- Bleep number/contact details	

Doctor receiving handover	
- Name	
- Grade	
- Specialty	
Senior clinical contact	If there is a particular requirement to call a specific person, e.g. consultant or SpR.

# Section three

## Handover: recommended headings for use in paper documents

The headings which are marked ✓ should be used in all paper based handover documents. In electronic documents all headings will be included but may not require completion in some clinical contexts.

Headings/sub-headings	Consultant team handover	Out of hours handover
Date	✓	✓
Time	✓	X
<b>Patient details</b>		
- Patient Surname, Forename	✓	✓
- Date of Birth	✓	✓
- NHS Number	✓	✓
- Gender	X	X
- Current Location	X	✓
- Intended Location	X	X
<b>Clinical details</b>		
- Date of Admission	✓	X
- Expected date of discharge	✓	X
- Discharge over weekend? Yes/No*	X	✓
- Responsible consultant	✓	✓
- New responsible consultant	✓	X
- Diagnosis/Problem List/Differential Diagnosis	✓	✓
- Mental Capacity	✓	X
- Advance decisions to refuse treatment and Resuscitation status	✓	X
- Mental State	X	X
- Patient at high risk	X	X

- Allergies	✓	x
- Risks/Warnings	✓	✓
<b>Reason for handover</b>	✓	✓
<b>Management Plan</b>		
- Clinical narrative	✓	x
- Current treatment/Investigations	✓	x
- Aims and Limitations of Treatment and Special Instructions	x	✓
- Escalation plan	✓	x
• Agreed with patient or legitimate patient representative (Y/N)	x	x
<b>Outstanding issues</b>	✓	x
- Tasks to be done		
• Task which MUST be done	x	✓
• Tasks to be done if possible	x	x
- Information given to patient and/or authorised representatives	✓	x
<b>Doctor Handing Over</b>		
- Name	✓	✓
- Grade	x	x
- Specialty	x	x
- Bleep Number/Contact Details*	✓	✓
<b>Doctor Receiving Hand Over</b>		
- Name	✓	✓
- Grade	x	x
- Specialty	x	x
- Bleep Number/Contact Details*	✓	✓
<b>Senior clinical contact</b>	x	x

\*These headings appear in paper documents only. In electronic documents the same information is managed differently.

# Section four

## Discharge summary: headings and definitions

The headings presented here are ‘anchor’ points for the clinical information in the discharge record. The detail and specialty specific requirements under each heading will be refined in work to follow. Not all headings are relevant in paper records nor on all occasions. In the electronic environment some of the headings will be automatically completed.

Suggested headings for paper discharge summaries are illustrated in the table on pages 21 to 23. An example of a recommended paper discharge summary can be found at <http://www.rcplondon.ac.uk>

Headings/sub-headings	Definition/illustrative description of the type of clinical information to be recorded under each heading
<b>GP details</b>	
- GP name	The name of the patient’s usual GP.
- GP practice address	The name and address of the patient’s registered GP practice.
- GP practice code	Code which defines the practice of the patient’s registered GP.
<b>Patient details</b>	
- Patient surname, forename	
- Name known as	
- Date of birth	
- Gender	
- NHS Number	
- Patient address	Patient’s usual address.
- Patient telephone number(s)	
<b>Admission details</b>	
- Method of admission	How the patient was admitted to hospital, e.g. emergency, elective, transfer, maternity.

- Source of admission	Where the patient was immediately prior to admission, e.g. usual place of residence, temporary place of residence, penal establishment.
- Hospital site	Physical site to which the patient was admitted.
- Responsible trust	The NHS hospital trust to which the patient was admitted (this may not be the same as the name of the hospital).
- Date of admission	
- Time of admission	Electronic environment only.
<b>Discharge details</b>	
- Date of discharge	
- Time of discharge	Electronic environment only.
- Discharge method	e.g. Patient discharged on clinical advice or with clinical consent; patient discharged him/herself or was discharged by a relative or advocate. Patient died (national code).
- Discharge destination	
• type of destination	Can include private dwelling, penal establishment, care home etc (national code).
• destination address	Not required if patient's own home.
• living alone	Yes or No.
- Discharging consultant	The consultant responsible for the patient at time of discharge.
- Discharging speciality/department	The speciality/department responsible for the patient at the time of discharge.
<b>Clinical information</b>	
- Diagnosis at discharge	Primary diagnosis, secondary diagnoses and relevant previous diagnoses, including complications and co-morbidities (e.g. for coding purposes).

Headings/sub-headings	Definition/illustrative description of the type of clinical information to be recorded under each heading
- Operations and procedures	New and relevant previous operations and procedures, including complications and adverse events.
- Reason for admission and Presenting complaints	The health problems and issues experienced by the patient resulting in their referral by a healthcare professional for hospital admission, e.g. chest pain, blackout, fall, a specific procedure, investigation or treatment.
- Mental capacity	The mental capacity of the patient to make decisions about treatment etc. Example, where an Independent Mental Capacity Advocate (IMCA) is required for decisions relating to discharge destination, medical treatment, ability to consent etc. Any information given to a significant other in relation to this matter.
- Advance decisions to refuse treatment and Resuscitation status	Written documents, completed and signed when a person is legally competent, that explain a person's medical wishes in advance, allowing someone else to make treatment decisions on his or her behalf later in the disease process. Includes Do Not Resuscitate orders.
- Allergies	Allergies, drug allergies and adverse reactions.
- Risks and warnings	Significant risk of an unfavourable event occurring, patient is Hepatitis C +ve, MRSA +ve, HIV +ve etc. Any clinical alerts, risk of self neglect/aggression/exploitation by others.
- Clinical narrative	Very brief narrative description of the in-patient episode. Should include complications and nutritional status.
- Relevant investigations and results	The relevant investigations performed and their respective results, where present, e.g. endoscopy, CT Scan etc. It is important to highlight investigations and test results which relate to a GP action.
- Relevant treatments and changes made to treatments	The relevant treatments which the patient received during the inpatient stay. Can include medications given whilst an inpatient.

- Measures of physical ability and cognitive function	e.g. Activity of Daily Living and cognitive function scale scores if not independent, weight/nutritional status at discharge.
- Medication changes	If admission medication stopped need to state reason. If medication started and stopped because of adverse reaction need to state reason.
- Discharge medications	Can include: <ul style="list-style-type: none"> <li>• medication dispensed on discharge</li> <li>• medication prescribed and not dispensed (e.g. patient's own)</li> <li>• medications to be commenced after discharge</li> <li>• NOMAD/ pill dispenser being used.</li> </ul>
- Medication recommendations	A medication recommendation about a drug or device allows a suggestion to be made for starting, discontinuing, changing or avoiding items in a patient's medication record. The medication recommendation may be made to another clinician or directly to the patient. Examples include: <ul style="list-style-type: none"> <li>• continue medication x and y</li> <li>• change dose of z after 3 weeks</li> <li>• consider change from medication a to med b if not effective</li> <li>• stop medication c and d</li> </ul>
<b>Advice, recommendations and future plan</b>	
- Hospital	Actions required/that will be carried out by the hospital department. To include: <ul style="list-style-type: none"> <li>• action (e.g. outpatient, pending investigations and results, outstanding issues)</li> <li>• person responsible</li> <li>• appropriate date and time.</li> </ul>
- GP	Actions required by the GP. To include: <ul style="list-style-type: none"> <li>• action (e.g. specific actions, pending investigations and results, outstanding issues, HRT and cervical screening)</li> <li>• person responsible</li> <li>• appropriate date and time</li> <li>• suggested strategies for potential problems, e.g. telephone contact for advice</li> </ul>

Headings/sub-headings	Definition/illustrative description of the type of clinical information to be recorded under each heading
- Community and specialist services	<p>Actions requested/ planned/ agreed with community services (community matron, palliative care, specialist nurse practitioner, rehab team, social services). To include:</p> <ul style="list-style-type: none"> <li>• action</li> <li>• person responsible</li> <li>• appropriate date and time.</li> </ul>
<b>Information given to patient and/or authorised representative</b>	<p>This can include:</p> <ul style="list-style-type: none"> <li>• relatives and carers</li> <li>• specific verbal advice and details of any discussions</li> <li>• written information including leaflets, letters and any other documentation.</li> </ul> <p>Differentiation required between information given to patients, carers and any other authorised representatives.</p>
<b>Patient’s concerns, expectations and wishes</b>	The patient’s expressed wishes, expectations and concerns.
<b>Results Awaited</b>	Y/N (If Yes please specify), e.g. pathology, investigations, imaging.
<b>Person completing summary</b>	
- Doctor’s name	
- Grade	
- Specialty	
- Doctor’s signature	Only needed on paper discharge record.
- Date of completion of discharge record	
<b>Distribution list</b>	

# Section four

## Discharge summary: recommended headings for use in paper

The headings which are marked ✓ should be used in all paper based discharge summaries. In electronic documents all headings will be included but may not require completion in some clinical contexts.

Headings/Sub-headings	Discharge Summary
<b>GP Details</b>	✓
- GP name	X
- GP practice address	X
- GP practice code	X
<b>Patient Details</b>	✓
- Patient surname, forename	✓
- Name known as	X
- Date of birth	✓
- Gender	✓
- NHS number	✓
- Patient address	✓
- Patient telephone number(s)	✓
<b>Admission Details</b>	✓
- Method of admission	✓
- Source of admission	X
- Hospital site	✓
- Responsible trust	✓
- Date of admission	✓
- Time of admission	X

Headings/Sub-headings	Discharge Summary
<b>Discharge Details</b>	X
- Date of discharge	✓
- Time of discharge	X
- Discharge method	X
- Discharge destination	✓
• type of destination	X
• destination address	X
• living alone	X
- Discharging consultant	✓
- Discharging speciality/ department	✓
<b>Clinical Information</b>	X
- Diagnosis at discharge	✓
- Operations and procedures	✓
- Reason for admission and Presenting complaints	✓
- Mental capacity	X
- Advance decisions to refuse treatment and Resuscitation status	X
- Relevant legal information*	✓
- Allergies	✓
- Risks and warnings	✓
- Clinical narrative	✓
- Relevant investigations and Results	✓
- Outstanding investigations*	✓
- Relevant treatments and changes made to treatments	X
- Measures of physical ability and cognitive function	✓
- Medication changes	✓

- Discharge medications	✓
- Medication recommendations	x
<b>Advice, Recommendations and Future Plan</b>	✓
- Hospital	✓
- GP	✓
- Strategies for potential problems*	✓
- Community and specialist services	✓
<b>Information Given to Patient and/or Authorised Representative</b>	✓
<b>Patient's Concerns, Expectations and Wishes</b>	x
<b>Results Awaited</b>	✓
<b>Person Completing Summary</b>	✓
- Doctor's name	✓
- Grade	✓
- Specialty	x
- Doctor's signature	✓
- Date of completion of discharge record	✓
- Bleep number*	✓
<b>Distribution list</b>	x

\*These headings appear in paper discharge summaries only. In electronic documents the same information is managed differently.

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