FORM HR-RM 1
(11-1-56)
Hall of Records Commission

REQUEST FOR RECORDS RETENTION SCHEDULE

To be Submitted to the Records Management Division
Hall of Records Commission

SCHEDULE NO. 373
PAGE NO. 1.

1. Requesting Agency: STATE DEPARTMENT OF HEALTH

2. Division or Bureau of Requesting Agency: COUNTY HEALTH DEPARTMENT RECORDS

3. Authorization Requested (Check only one of the squares below).

A ☐ Dispose of present accumulation. No additional accumulation is anticipated. Records have ceased to have value to warrant retention.

B ☒ Establish retention schedule for records for which there is a continuing accumulation. The records will cease to have value to warrant their retention after the period of time indicated.

C ☐ Microfilm and destroy originals. Originals if not microfilmed would be retained for the period of time indicated.

4. Item No.	5. Description of Records Describe records accurately. Include title, form number, size of documents, work or activity to which the records relate, inclusive dates, and quantity (cubic or linear feet). Show recommended retention period.	6. Recommendation of Hall of Records and Board of Public Works.
1.	CANCER CASE FILES Dates: 1946 - - File Arrangement: Alphabetical Cancer case histories are maintained on forms designed and supplied by the American Cancer Society. These are: MD ACS - 7 Cancer Clinic Record MD ACS - 9 Consultation Record Other records which may be included in the file are: Laboratory Reports Correspondence Besides the copy of the forms filed in the county health departments several others are prepared and distributed to the following: Maryland Chapter of the American Cancer Society Patient's Physician State Department of Health - Cancer Control Services - this copy is scheduled for destruction after three years retention (Schedule No. 228, Item 2) The copy retained by the county departments has no value after a few years retention. The State Department maintains a permanent register of individuals whose laboratory reports show suspicious or	APPROVED HALL OF RECORDS COMMISSION

7. Agency, Division or Bureau Representative

[signature] | [illegible] Program Analyst & Records Mgmt. | 9/7/60
Signature | Title | Date

Schedule Authorized as Indicated in Col. 6 by Hall of Records Commission.

11/1/1960 — Date
Marion S. Richoff — Archivist

Disposal Authorized as Indicated in Col. 6 by Board of Public Works.

NOV 7 1960 — Date
[signature] — Secretary

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positive findings (Schedule No. 228, Item 3 and Schedule No. 221, Item 2). The recommendation below applies only to the records filed in the county health departments. No follow-up is made by County health department and the records have no value after a short period.

RECOMMENDATION: RETAIN FOR THREE YEARS AND THEN DESTROY

2. DENTAL HEALTH RECORDS

Dates: 1943 - -

Generally the dental records in the county departments are maintained in family folders; a few counties, however, maintain them in individual clinic case folders.

DH 12 Pre-school Dental Examination
OH 13 Treatment Record
DH-20 Dental Inspections

RECOMMENDATIONS: RETAIN FOR THREE YEARS AFTER DATE OF LAST ENTRY AND THEN DESTROY.

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3. TUBERCULOSIS REGISTER

Quantity: Varies from 1 - 5 cubic feet
File Arrangement: Alphabetical

All counties maintain a tuberculosis register. For this purpose most of the counties use a standard form - TB 14 - which shows: patient's name, address, age, sex, race, occupation, marital status, whether veteran, date reported, physician, prognosis, results of laboratory and X-ray examinations, clinic visits, and remarks. A contact record on Form CD-33A is also maintained showing names of individuals with whom a tubercular patient is closely associated, generally members of the patient's household.

A few of the counties use a form designed by the U.S. Public Health Service. This form combines all the information contained on the two forms mentioned above.

All information regarding the patient's progress, laboratory and X-ray results, etc., is summarized on the Tuberculosis History Card maintained on all tuberculosis patients in Maryland in the central file of the Bureau of Tuberculosis, State Department of Health. The recommendation below applies only to the county tuberculosis registers.

RECOMMENDATION: RETAIN UNTIL DEATH OF PATIENT AND THEN DESTROY.

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REQUEST FOR RECORDS RETENTION SCHEDULE
(Continuation Sheet)

SCHEDULE NO. 273

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4. Item No.	5. Description of Records Describe records accurately. Include title, form number, size of documents, work or activity to which the records relate, inclusive dates, and quantity (cubic or linear feet). Show recommended retention period.	6. Recommendation of Hall of Records and Board of Public Works.

4. MASS CHEST X-RAY SURVEY DATA

Mobile chest X-ray units visit the counties periodically. The following records result from this operation.

Thirty-five (35) and seventy (70) millimeter film - containing the X-ray picture. Each picture is identified by number.

IBM punch cards - showing the X-ray number, individual's name, address, race, and result of X-ray examination. These cards are sent to the counties in numerical order.

IBM - Tabulation Sheets - these sheets are printed from the punch card and show the same information. They are printed in numerical order and were at one time sent to the counties. Now only the cards and not the sheets are sent to the counties.

Lists of names of individuals whose X-rays indicate the possibility of tuberculosis and other abnormalities being present (Form TB-3). These lists are in alphabetical order and show the patient's name, address, and X-ray number.

After the film is read and the lists prepared, all of the records are forwarded to the county. None of the counties are equipped to read the film; the tabulation lists of negative results and the IBM cards are used only occasionally. These few instances of reference occur when a subsequent X-ray shows the presence of tuberculosis and the diagnostician wishes to check on the earlier X-ray to see if it was misread. Because the cards and the tabulated lists are in numerical order, locating the record of an individual is a time consuming operation. This is especially true in some counties where many thousands of individual pictures are taken.

Individuals whose X-ray shows positive or doubtful tuberculosis are asked to return for further examination and their names are placed in the permanent tuberculosis register in the State Health Department, and a case history folder is initiated in the county.

RECOMMENDATION: RETAIN FOR THREE YEARS AND THEN DESTROY.

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5. TUBERCULOSIS REPORTS SHOWING NEGATIVE RESULTS

Dates: 1926 - -
File Arrangement: Alphabetical

This item includes the records concerning an individual examined for tuberculosis with negative results. The records included are:

TB - 23 Physician's Report - The county health officers report to the family physician regarding a patient referred to the county chest clinic.

Item	5. Description of Records Describe records accurately. Include title, form number, size of documents, work or activity to which the records relate, inclusive dates, and quantity (cubic or linear feet). Show recommended retention period.	6. Recommendation of Hall of Records and Board of Public Works.

TB - 6 Tuberculosis Record
BL - 9 Laboratory Report
Correspondence

RECOMMENDATION: RETAIN FOR THREE YEARS AND THEN DESTROY.

6. TUBERCULOSIS CASE RECORDS

Dates: 1926 - -
Index: TB Register and Master Index

The following records are included in this item:

TB - 6 Tuberculosis Record - Medical, Nursing, Social: shows patient's name, address, physical description, employment, name of physician, previous tuberculosis or other significant medical history, present symptoms, X-ray interpretation, extent of present tubercular infection, recommendations, results of sputum analysis, results of tuberculin tests, and notes of physician and public health

TB - 6b Tuberculosis Contact Record - record of tubercular findings of contacts of known tubercular patients.

TB - 2 Application for Admission to Maryland Tuberculosis Hospitals

TB - 12 Social Service Face Sheet Information on TB patients

TB - 18 Public Health Nurse's Report on Patient and Home Situation for Tuberculosis Hospitals

TB - 23 Physician's Report - County health officers report to family physician regarding patient referred to county Tuberculosis clinic

MTA - 50 Chest Clinic Record (Patient) Maryland Tuberculosis Association History form (This form is now obsolete).

RECOMMENDATION: RETAIN UNTIL DEATH OF INDIVIDUAL OR FOR FIFTY YEARS, WHICHEVER OCCURS EARLIER, AND THEN DESTROY.

7. TUBERCULOSIS CORRESPONDENCE - GENERAL

Dates: 1945 - -
File Arrangement: Subject and alphabetical therein

Correspondence concerned with the chest clinics and mass chest X-ray survey. It is with Federal, State, local and other state agencies, civic and professional organizations, physicians, etc.

RECOMMENDATION: RETAIN FOR THREE YEARS AND THEN DESTROY.

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Item No.	5. Description of Records Describe records accurately. Include title, form number, size of documents, work or activity to which the records relate, inclusive dates, and quantity (cubic or linear feet). Show recommended retention period.	6. Recommendation of Hall of Records and Board of Public Works.

8. CHEST CLINIC MONTHLY REPORTS AND CLINICIAN PAYROLLS

Size: 8½" x 11"
Dates: 1952 - -
File Arrangement: Chronological

TB-1 This is an invoice form prepared by the county health officer for payment of physicians and clinicians for services rendered in the county chest clinics. The form is prepared in triplicate, two copies are sent to the State Department of Health for processing and payment, the other copy is retained in the county file. This copy is not audited.

TB - 15 Chest Clinic - Monthly Report. This is a statistical record of each day's activities in the county chest clinics.

RECOMMENDATION: RETAIN FOR THREE YEARS AND THEN DESTROY.

9. COMMUNICABLE DISEASE RECORD

File Arrangement: By disease and chronological therein

Specific diseases must be reported to the county health officer by the physician making the diagnosis. The health officer is further required to keep a record of such reported diseases (Art. 43, Secs. 78 and 79, Annotated Code of Maryland, 1957 Edition).

The physician reports the disease on a standard post-card, U.S. Public Health Service form No. 1407 or State Health Department Form CD 1 (Rev. 7-58) and the county health department records the information in a register maintained for that purpose or as in some counties copies the information for certain diseases on another card. In either instance the original form (PHS 1407 or CD 1) is forwarded to the State Department of Health. The information shown in the county record is: name of disease, patient's name, address, date of onset, hospital, school, place of work, any remarks, and the name of the physician making the diagnosis. The recommendation below applies only to the duplicate records maintained by the county health departments.

RECOMMENDATION: RETAIN FOR FIVE YEARS AND THEN DESTROY.

10. VENEREAL DISEASE CLINIC RECORDS - SYPHILIS

Dates: 1925 - -
File Arrangement: Alphabetical

The following records are maintained as case files on individuals having this infection:

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VD - 25D Venereal Disease Registration and Preliminary Examination Record
CD - 25 Venereal Disease History Chart and Treatment Card
Laboratory Reports (including syphilis serological ozalid copy - 12-58-75m)
Correspondence

Because of the possibility of recurrence of the disease or later manifestations of it, the records must be retained for many years.

RECOMMENDATION: RETAIN UNTIL INDIVIDUAL REACHES AGE FIFTY, OR UNTIL DEATH, WHICHEVER IS EARLIER, AND THEN DESTROY.

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11. VENEREAL DISEASE EPIDEMIOLOGIC AND CASE HOLDING REPORT

Form No.: CD 41-B and PHS - 2936 (6-58)
Size: 5" x 8"
Dates: 1949 - -
File Arrangement: Alphabetical

This report is used to trace suspected cases of venereal disease so that treatment can be given the infected person, thus helping to prevent further spread of the disease and its disabling consequences.

The report is prepared in quadruplicate and distributed as follows:

1. County Health Department - (this item)
2. and 3. Division of Venereal Disease Control, State Department of Health
4. Investigating officer's copy

Information shown on the form is the suspected contact's name, address, and physical description, name of informant, place and date of encounter, relation of the parties and details of the disposition of the case.

RECOMMENDATION: RETAIN FOR FIVE YEARS AND THEN DESTROY.

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12. VENEREAL DISEASE CLINIC RECORDS - GONORRHEA, CHANCROID, GRANULOMA INGUINALE AND LYMPHOGRANULOMA VENEREUM.

Dates: 1925 - -
File Arrangement: Alphabetical

Records maintained on patients having gonorrhea and the other infections listed above are:

CD - 25 Venereal Disease History Chart and Treatment Card
CD - 25D and V.D.-25D (rev.) Venereal Disease Registration and Preliminary Examination Record
Laboratory Reports

Case records concerned with these diseases, due to modern medical

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progress, have no value shortly after the case is diagnosed.

RECOMMENDATION: RETAIN FOR THREE YEARS AND THEN DESTROY.

13. VENEREAL DISEASE STATISTICAL REPORTS

Size: 8½" x 11"
Dates: 1946 - -
File Arrangement: Chronological

VD - 47 Venereal Disease Register - shows date, patient's name, diagnosis and treatment; prepared weekly and forwarded to the Division of Venereal Disease Control.

VD-48 Monthly Report of Diagnostic Observation for VD (recap of daily reports)

PHS 724-1 U.S. Public Health Service Form prepared monthly for each county by the Division of Venereal Disease Control, is a statistical summary of all venereal disease control activities in the county.

RECOMMENDATION: RETAIN FOR THREE YEARS AND THEN DESTROY.

14. VENEREAL DISEASE DRUG REPORT - MONTHLY

Form No.: VD-45
Size: 8½" x 11"
Dates: 1950 - -
File Arrangement: Chronological
Annual Accumulation: Discontinued

This monthly report is submitted to the State Health Department for inventory control and ordering purposes. The form shows by type of drug amounts on hand, amounts used, and amounts distributed to other agencies and physicians. The preparation of this report was discontinued in July 1956.

RECOMMENDATION: DESTROY ACCUMULATION.

15. POLIOMYELITIS VACCINATION RECORD

Size: 3" x 5"
Dates: 1955 - -
File Arrangement: Alphabetical

This card shows name, address, age, race, sex, school and grade, whether parental request was received, and dates of innoculations. This information is also noted on the pediatric health record (MCH-7) in the Public Health Nurses' Case Files.

RECOMMENDATION: RETAIN FOR FIVE YEARS AND THEN DESTROY.

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16. IMMUNIZATION RECORD

Form No.: MCH - 22
Size: 3" x 5"
Dates: 1947 - -
File Arrangement: Alphabetical

This card shows name, address, ages, sex and race, type of immunization (not including poliomyelitis) and date of innoculation. Immunizations are also noted on the pediatric health record (Form MCH-7) which is retained for five years (see Item 32).

RECOMMENDATION: RETAIN FOR FIVE YEARS AND THEN DESTROY.

17. MEDICAL CARE DAILY RECORD (CONTROL OVER CASE NUMBERS ASSIGNED)

Size: 8½" x 11"
Dates: 1945 - -
File Arrangement: Chronological

Some of the county health departmentsmaintain this file for care control. The form shows the name of the individual applying for medical care, whether it is a new, rejected or reactivated case, case number, whether medical indigent or welfare indigent and the date of closure.

RECOMMENDATION: RETAIN PERMANENTLY.

18. MEDICAL CARE CASE SUMMARY RECORD

Form No.: MS-8
Size: 8½" x 11" (card) or 6" x 9"
Dates: 1945 - -
File Arrangement: Alphabetical

The counties maintain this record on each individual receiving aid through the Medical Care Program. The card shows the individual's name, address, case number, age, sex, color, period during which individual is eligible for care, services rendered, by whom, date, diagnosis, remarks, whether office or home visit, and the amount of the bill. The card is ruled on both sides and a total of forty entries can be made.

RECOMMENDATION: RETAIN FOR FIVE YEARS AFTER DATE OF LAST ENTRY AND THEN DESTROY.

19. MEDICAL CARE CASE FILE

Dates: 1945 - -

The Medical Care Program is a system by which indigent and/or medically indigent citizens receive medical and dental care and drugs paid for by the State.

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Eligibility to receive this aid is determined by the State Department of Public Welfare. The case file contains the records necessary for individuals to obtain the financial assistance offered by the program. There are no medical, nursing, or clinical notes in the individual case folders.

The folders contain one or more of the following documents:

MS - 1 Application for Medical Care
MS - 1e Report of Need for Dentures
MS - 3 Request for Authorization of Eyeglasses for Foster Children
MS-K Certification of Employer
MS-L Wage Information
MS-P Old Age Insurance Information
SDPW-206 Certification of Eligibility for Medical Service by Welfare Department
MS-4 Medical Report and Doctor's Invoice (copy)
MS-5 Dental Report and Dentist's Invoice (copy)
MS-6 Prescription and Pharmacist's Invoice (copy)
MS-7 Hospital Report and Invoice (copy)
Correspondence

(Forms MS-4-7) are no longer retained by the county. They are forwarded to the State Department of Health and filed there.

All payments are made by the Bureau of Management, State Department of Health, and the accounts are audited there. No audit is made of the medical case records at the county level. The counties, however, maintain a record of all medical care payments on Form MS-8 (See Item 18).

RECOMMENDATION: RETAIN FOR THREE YEARS AFTER DATE OF LAST ENTRY AND THEN DESTROY.

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20. MEDICAL CARE GENERAL CORRESPONDENCE

Dates: 1945 - -

This is correspondence concerned with the Medical Care Program in the county. It is with Federal, State, local and other-state agencies, doctors, dentists, pharmacists, civic and professional organizations, etc. Correspondence concerned with a particular individual receiving medical care is placed in the individual's case folder.

RECOMMENDATION: RETAIN FOR THREE YEARS AND THEN DESTROY.

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21. MEDICAL CARE PROGRAM PAYROLLS

Size: IBM Tabulation Sheets
Dates: 1945 - -

Bills of physicians, dentists, and pharmacists are forwarded to the Accounting Division, State Health Department for processing and payment. The processing is accomplished on IBM punch-card equipment.

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and each bill is printed on tabulation sheets. At one time a carbon of the tabulation sheet was returned to the county where it was used to check payment records and occasionally to verify payment or lack of it. Information on the sheet is: physician's, dentist's, or pharmacist's name and address, purpose of payment, month bill was rendered, medical care case number, and the amount paid. The tabulation sheet is no longer returned to the county. Counties now receive a copy of the voucher which accompanies the check.

RECOMMENDATION: RETAIN FOR THREE YEARS AND THEN DESTROY.

22. FISCAL RECORDS

State funds dispersed by county health departments are audited and controlled by the Bureau of Management of the State Department of Health. There are a few special funds appropriated by county commissioners for the use of the county board of health. These funds are audited by the county auditors but may be included in the State Department budget, in which case they are audited by the Bureau of Management, not the county. The copies of fiscal records retained by some counties are used only for administrative, inventory, and budget purposes, and are not required for audit. Records retained by other counties are required for audit if disbursements are made directly by the county departments. The following is a list of records used by the county departments:

BM-2 Expense Voucher
BM-2A Reimbursement of Petty Cash - Office Expense Account
BM-4 Summary of Expense Account - Field Employees-monthly
BM-5 Mileage Report (or local equivalent)
BM-8 Order for supplies
BM-9 Requisition for supplies
BM-11 Invoice - bill to county commissioners for care of patients in State Department of Health Hospital
BM-18A Partial Report of Materials Received (or local equivalent)
BM-21 Daily Sign-in and out Sheet (or local equivalent)
BM-21A Bi-Weekly Attendance Report (or local equivalent)
SDH-28 Statement for Clinic Services (invoice)
BL-70A Requisition for Specimen Mailing Outfits

RECOMMENDATION: IF AUDITED: RETAIN UNTIL ALL AUDIT REQUIREMENTS BOTH STATE AND COUNTY HAVE BEEN MET, OR FOR THREE YEARS, WHICHEVER IS LATER, AND THEN DESTROY.
IF NOT AUDITED: RETAIN FOR THREE YEARS AND THEN DESTROY.

23. SANITATION INSPECTION FILE

Dates: 1940 - -

County sanitarians inspect all establishments handling food whether wholesale, retail, processor or farm, recreational areas, public buildings, schools, nursing homes, hospitals, etc. The following inspection forms are used:

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U. S. Public Health Service Forms

USPHS - A	Shucking and Packing Plant
PHS - 723 (SE)	Pasteurization Plant
PHS - 985 (SE)	Eating and Drinking Establishments
8976-A	Milk Producer - Distributor
8976-D	Milk Plant - Producer

State Department of Health Forms

SL - 3	School Lunch Room Sanitation Report
F & D 16	Sanitary Report - Cannery
F & D 63	Dairy Form (Producer-Distributor)
F & D 63-A	Dairy Form (Shipper)
F & D 82	Crab Meat Plants
F & D 100	Bottling Plant
	Zero Locker Inspection Report

Laboratory Reports

BL - 7	Bacteriological Water Report
BL 20	General Laboratory Report
BL - 22	Sanitary Survey of Shellfish
BL - 25	Bacterial Reports on Milk Shippers
BL - 131	Bacteriological Examination of Eating and Drinking Utensils
BL - 191	Bacteriological Shellfish Report
BL - 221	Water Analysis
BL - 222	Water Analysis
BL - 243	Bacteriological Report on Swimming Water
BL - 245	Chemistry - Food Report
BL - 246	Chemistry - Food Report
BL - 247	Chemistry - Food Report
BL - 248	Milk and Related Products
BL - 273	Crabmeat Report

Locally devised inspection forms are used by a few of the county health departments. It is intended that local forms be included in this item.

Inspections are made periodically, generally at least once a year. Where the inspection report or laboratory report indicates the need for some corrective measure, the owner or operator of the establishment is notified and corrective action is generally instituted immediately.

RECOMMENDATION: RETAIN FOR THREE YEARS AND THEN DESTROY.

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Item No.	5. Description of Records Describe records accurately. Include title, form number, size of documents, work or activity to which the records relate, inclusive dates, and quantity (cubic or linear feet). Show recommended retention period.	6. Recommendation of Hall of Records and Board of Public Works.

24. WATER SUPPLY AND SEWAGE DISPOSAL SYSTEMS - APPLICATIONS, INSPECTIONS, APPROVALS

Dates: 1941 - -

County health departments are responsible for inspecting and approving both public and private water supply and sewage disposal systems. Except for laboratory reports, local forms are used for this purpose. Usually the file consists of the following documents:

Application for permit to construct sewage disposal and/or water supply system
Approval of water supply and/or sewage disposal systems plans
Approval of completed system
Inspection report
Laboratory reports
Plats - subdivision (also filed by State Department of Health)
Plans of water supply and sewage disposal systems (also filed by State Department of Health)

RECOMMENDATION: RETAIN FOR THREE YEARS AND THEN DESTROY.

25. COMPLAINT FILE - PUBLIC HEALTH NUISANCES

Complaints are handled by the county sanitarian. They are received by mail and by phone, if by the latter a memorandum is prepared. Complaints are investigated immediately and usually settled within thirty days. The file contains the following records:

Record of Complaint - correspondence or telephone memorandum
Sanitarian's report - narrative, shows findings, recommendations, and final results

RECOMMENDATION: RETAIN FOR THREE YEARS AND THEN DESTROY.

26. DAILY REPORT OF SANITATION SERVICES

Form No.: F & D 126 and FC - 126
Dates: 1950 - -
Size: 8½" x 11"
File Arrangement: Chronological

This report is prepared daily by each sanitarian. It shows the type and number of establishments inspected and any remarks. The report is forwarded to the Division of Food Control Data is usually summarized in monthly reports, duplicates of which are also forwarded to the Division. The recommendation below applies to both the daily and monthly reports.

RECOMMENDATION: RETAIN FOR THREE YEARS AND THEN DESTROY.

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Item No.	5. Description of Records Describe records accurately. Include title, form number, size of documents, work or activity to which the records relate, inclusive dates, and quantity (cubic or linear feet). Show recommended retention period.	6. Recommendation of Hall of Records and Board of Public Works.

27. PUBLIC HEALTH NURSING REPORTS

Size: 8½" x 13"
Dates: 1943 - -

Public Health Nurses' notes regarding specific patients or families are located in the family case folders, clinic folders, or case history folders, according to the practice of the county department. This item is concerned with the nurses' statistical reports and other records not concerned with specific patients.

PHN - 7 Request for Health Department Services (formerly SD-21B)
* PHN - 20 Daily Report of Public Health Nursing Services
* PHN - 21 Monthly Report of Public Health Nursing Services - original forwarded to State Department of Health
PHN - 11 Monthly Report of Public Health Nurse, Obstetrics

* PHN-20 & 21 replaced by PHN 136A & 136B. These are mark-sensed cards.

RECOMMENDATION: RETAIN FOR THREE YEARS AND THEN DESTROY.

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28. PUBLIC HEALTH NURSES - GENERAL CORRESPONDENCE

This correspondence is concerned with the Public Health Nursing program of the county. It is with Federal, State, local and other state agencies, professional and civic organizations, individuals, doctors, dentists, hospitals, etc. Correspondence concerned with individuals for whom some service is performed is filed in the individual case folder.

RECOMMENDATION: RETAIN FOR THREE YEARS AND THEN DESTROY.

29. PUBLIC HEALTH OFFICER - GENERAL CORRESPONDENCE

Size: 8½" x 11"
File Arrangement: Alphabetical by name, subject, or disease

This item is composed of the County Health Officer's correspondence with other Health officers, health centers, hospitals, State and county agencies, individuals, companies, and public, private, or professional organizations interested in public health administration. Correspondence with or about individual patients is filed in clinical case folders and is not governed by the recommendation below.

RECOMMENDATION: RETAIN FOR THREE YEARS AND THEN DESTROY.

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REQUEST FOR RECORDS RETENTION SCHEDULE
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Item No.	5. Description of Records Describe records accurately. Include title, form number, size of documents, work or activity to which the records relate, inclusive dates, and quantity (cubic or linear feet). Show recommended retention period.	6. Recommendation of Hall of Records and Board of Public Works.
30.	MATERNITY CASE FILES Size: 8½" x 11" File Arrangement: Alphabetical by name of patient These clinical records are maintained on forms supplied by the Division of Maternal and Child Health, State Department of Health, and on forms devised by the County Health Department. Generally, the maternity case records are retained in family folders which also contain the treatment records of other members of a patient's family. Some counties maintain the records in individual clinic case folders as well as family folders. The records which may be filed in the individual or family folder include: MCH 8, Maternity Record - History MCH 8-A Maternity Record - History of present pregnancy RECOMMENDATION: RETAIN UNTIL PATIENT REACHES AGE FORTY-FIVE OR UNTIL DEATH, WHICHEVER IS EARLIER, AND THEN DESTROY.	APPROVED HALL OF RECORDS COMMISSION
31.	GYNECOLOGICAL CASE FILES Size: 8½" x 11" File Arrangement: Alphabetical by name of patient These clinical records are maintained on forms supplied by the Division of Maternal and Child Health, State Department of Health, and on forms devised by the County Health Department. Generally, the gynecological case records are retained in family folders which also contain the treatment records of other members of a patient's family. Some counties maintain the records in individual clinic case folders as well as family folders. The records which may be filed in the individual or family folder include: Gynecological clinical data - recorded during initial interview with patient and subsequent physical examination Summaries of re-visit consultations (gynecological) Correspondence with patient RECOMMENDATION: RETAIN UNTIL PATIENT REACHES AGE FORTY-FIVE OR UNTIL DEATH, WHICHEVER IS EARLIER, AND THEN DESTROY.	APPROVED BY BOARD OF PUBLIC WORKS NOV 7 1960 SECRETARY
32.	PEDIATRIC CASE FILES Size: 8½" x 11" File Arrangement: Alphabetical by name of patient Pediatric Clinic records are usually maintained on forms supplied by the Division of Maternal and Child Health, Maryland State Department of Health. Generally the pediatric case records are retained	

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in family folders which also contain the treatment records of other members of a patient's family. Some countiesmaintain the records in individual clinic case folders as well as family folders. The records which may be filed in the individual or family folder include:

MCH 7, Pediatric Health Record - for infant to age 6
Correspondence concerning the patient

RECOMMENDATION: RETAIN FOR FIVE YEARS AFTER DATE OF LAST ENTRY AND THEN DESTROY.

33. HEARING CASE FILES

Size: 8½" x 11"
File Arrangement: Alphabetical by name of patient

These clinical records are usually maintained on forms which are devised by the County Health Departments. Generally the hearing case records are retained in family folders which contain the treatment records of other members of a patient's family. Some counties maintain the records in individual clinic case folders as well as family folders. The records which may be filed in the individual or family folder include:

Hearing Clinic Record - summarizing patient's history and the results of physical examination
Correspondence

RECOMMENDATION: RETAIN FOR FIVE YEARS AFTER DATE OF LAST ENTRY AND THEN DESTROY.

34. VISION CONSERVATION CASE FILES

Size: 8½" x 11"
File Arrangement: Alphabetical by name of patient

These clinical records are maintained on forms supplied by the Division of Maternal and Child Health, State Department of Health, and on forms by the County Health Departments. Generally the vision case records are retained in family folders which contain the treatment records of other members of a patient's family. Some counties maintain the records in individual clinic case folders as well as family folders. The records which may be filed in the individual or family folder include:

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Results of eye examination or re-examination
Vision Test Results - for use by schools
Correspondence

RECOMMENDATION: RETAIN FOR FIVE YEARS AFTER DATE OF LAST ENTRY AND THEN DESTROY.

35. ORTHOPEDIC AND PLASTIC CASE FILES

Size: 8½" x 11"
File Arrangement: Alphabetical by name of patient

These clinical records are maintained on forms supplied by the State Department of Health, and on forms devised by the County Health Departments. Generally the orthopedic and plastic case records are retained in family folders which contain the treatment records of other members of a patient's family. Some counties maintain the records in individual clinic case folders as well as family folders. The records which may be filed in the individual or family folder include: Local forms pertaining to treatment of patient by the clinic--e.g. pediatric summary--for consultation, seizure, and neurology.
SCC 18, patient's personal and health history
Correspondence

RECOMMENDATION: RETAIN UNTIL PATIENT REACHES AGE THIRTY, OR UNTIL DEATH, WHICHEVER OCCURS EARLIER, AND THEN DESTROY.

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36. CARDIAC CASE FILES

Size: 8½" x 11"
File Arrangement: Alphabetical by name of patient

These clinical records are maintained on forms supplied by the State Department of Health, and on forms devised by the County Health Departments. Generally the cardiac case records are retained in family folders which contain the treatment records of other members of a patient's family. Some counties maintain the records in individual clinic case folders as well as family folders. The records which may be filed in the individual or family folder include:

SCC 13, patient history and physical examination results
SCC 13-B, Electrocardiographic Report - includes electrocardiogram
Correspondence

RECOMMENDATION: RETAIN UNTIL PATIENT REACHES AGE THIRTY, OR UNTIL DEATH, WHICHEVER OCCURS EARLIER, AND THEN DESTROY.

REQUEST FOR RECORDS RETENTION SCHEDULE
(Continuation Sheet)

SCHEDULE NO. 373

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Item No.	5. Description of Records Describe records accurately. Include title, form number, size of documents, work or activity to which the records relate, inclusive dates, and quantity (cubic or linear feet). Show recommended retention period.	6. Recommendation of Hall of Records and Board of Public Works.

37. ELECTROCARDIOGRAPHIC REPORTS

Form No.: SCC 13-B
Size: 8½" x 11"
File Arrangement: Alphabetical by name

Some county health departments file electrocardiographic reports on persons who are not regular clinical patients. These persons are recommended for testing by private physicians and the original report is forwarded to the recommending physician. The recommendation below applies only to copies of reports retained by the county health department.

RECOMMENDATION: RETAIN FOR THREE YEARS AND THEN DESTROY

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38. MENTAL HEALTH CASE FILES

Size: 8½" x 11"
File Arrangement: Alphabetical by name of patient

These clinical records are maintained on forms supplied by the Division of Mental Health, State Department of Health and also on forms which are locally devised. These records are usually filed in an individual patient's case folder used for clinical purposes. The records which may be filed in the individual folder include:

Mental Health Clinic Referral - School Information
DMH-1 (Rev. 7/58), Mental Health Clinic - Patient Service Record - gives personal information, type of service and condition after treatment, diagnosis, disposition, and record of interviews with patient or others interested in patient, and the date of termination (copy forwarded to Division of Mental Health)
Mental Hygiene Clinic Referral - Adult (summarizes patient's personal history)
Mental Hygiene Clinic Referral - Child (summarizes patient's personal history
Typescript summaries of interviews with patients
Correspondence

RECOMMENDATION: RETAIN UNTIL DEATH OF PATIENT AND THEN DESTROY.

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39. REPORT OF MENTAL HEALTH CLINIC SERVICES

Form No. DMH-2 (Rev. 7/58)
Size: 8½" x 11"
File Arrangement: Chronological

REQUEST FOR RECORDS RETENTION SCHEDULE
(Continuation Sheet)

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This is a statistical report which is prepared at County level and forwarded to the Division of Mental Health, State Department of Health. The report summarizes services on a daily, weekly, or monthly basis and gives admissions and terminations during the period covered by the report, totals of various types of services to patients, and the number of man hours spent by clinical staff on community services of various types.

RECOMMENDATION: RETAIN FOR FIVE YEARS AND THEN DESTROY.

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