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Medical Record Requirements in New Mexico

Medical record violations are one of the most common issues cited by the New Mexico Board of Veterinary Medicine in disciplinary cases. In addition to supporting continuity of care, medical records serve as legal documentation of the services provided and the clinical decision-making of the veterinarian. The requirements for record keeping are established in the New Mexico Veterinary Practice Act and further defined in 16.25.9.21 NMAC (Record Keeping).

This article summarizes the minimum elements required for a medical record to be considered complete and compliant.

Requirement to Maintain a Medical Record

A veterinarian-client-patient relationship (VCPR) requires that a legible individual or group medical record be created and maintained for any animal receiving veterinary services. This requirement applies to all encounters, regardless of the nature or duration of the visit.

Required Client and Patient Identification

Each medical record must clearly identify both the client and the patient. At a minimum, this includes:

- Owner or agent name, address, and telephone number
- Animal identification, including:
  - Name or unique identifier
  - Species
  - Breed
  - Age
  - Sex
  - Weight
  - Color, where appropriate

The purpose of this requirement is to ensure that the patient and responsible party can be clearly and reliably identified from the record alone.

Required Clinical Content

The medical record must include sufficient clinical detail to document the care provided and support the veterinarian's medical decision-making. Required elements include:

History

A record of pertinent history relevant to the presenting complaint or condition.

Physical Examination Findings

Documentation of examination findings. Entries should reflect the observations made and should not be limited to conclusory statements without supporting detail.

Assessment and Plan

A working diagnosis or differential diagnoses, along with the intended diagnostic and/or therapeutic plan.

Treatments and Medications

Complete documentation of all treatments administered or prescribed, including:

- Drug name
- Strength or concentration
- Dosage
- Route of administration
- Frequency
- Duration, when applicable

All anesthetic events must be documented, including premedication, induction agents, maintenance agents, and any additional drugs administered during the procedure.

Documentation of Client Communication and Informed Consent

In addition to clinical findings and treatments, the medical record must reflect substantive communications with the client or the client's agent.

Records should document:

- Recommendations made to the client, including diagnostic tests, treatments, and procedures
- Risks, benefits, and reasonable alternatives when applicable
- The client's decisions regarding those recommendations

It is particularly important to document whether the client accepts or declines recommended diagnostics or treatments. When recommendations are declined, the record should reflect that the client was informed of the potential consequences of declining care when such discussion is clinically relevant.

Documentation must be sufficient to demonstrate that informed consent was obtained or that informed refusal occurred.

Controlled Substances Documentation

When controlled substances are used or dispensed, a separate controlled substance log must be maintained. This log must include:

- Date and time of use
- Client name
- Patient identification
- Amount used
- Remaining balance
- Identification of the responsible veterinarian and, when applicable, staff member

This requirement is separate from, and in addition to, documentation in the medical record.

Record Retention and Availability

Medical records must be retained for a minimum of four years from the date of the last patient encounter. Records must be maintained in a manner that allows for timely retrieval and review.

Upon written request by the client, copies or summaries of the medical record must be provided within ten working days.

Common Deficiencies

- Incomplete or missing patient signalment
- Limited or absent physical examination documentation
- Incomplete medication records
- Lack of documented assessment or treatment plan
- Failure to document client communications
- Inadequate documentation of anesthetic events

Conclusion

A complete medical record must clearly document the identity of the patient and client, the clinical findings, the medical decision-making process, the treatments provided, and the communications that informed those decisions. Following these requirements will help you avoid a violation if a complaint is brought against you before the Board.