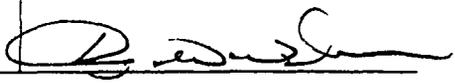
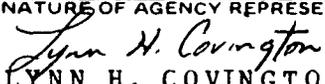


<b>REQUEST FOR RECORDS DISPOSITION AUTHORITY</b> <i>(See Instructions on reverse)</i>		LEAVE BLANK	
TO: <b>GENERAL SERVICES ADMINISTRATION</b> <b>NATIONAL ARCHIVES AND RECORDS SERVICE, WASHINGTON, DC 20408</b>		JOB NO. <b>N1-15-87-4</b>	DATE RECEIVED <b>3/3/87</b>
1. FROM (Agency or establishment) <b>VETERANS ADMINISTRATION</b>		NOTIFICATION TO AGENCY	
2. MAJOR SUBDIVISION <b>Department of Medicine and Surgery</b>		In accordance with the provisions of 44 USC 3303a the disposal request, including amendments, is approved except for items that may be marked "disposition not approved" or "withdrawn" in column 10. If no records are proposed for disposal, the signature of the Archivist is not required.	
3. MINOR SUBDIVISION <b>VA Field Facilities</b>		DATE <b>4/1/88</b>	ARCHIVIST OF THE UNITED STATES 
4. NAME OF PERSON WITH WHOM TO CONFER <b>Mrs. Marjorie M. Leandri</b>	5. TELEPHONE EXT. <b>233-3662</b>		
6. CERTIFICATE OF AGENCY REPRESENTATIVE			

I hereby certify that I am authorized to act for this agency in matters pertaining to the disposal of the agency's records, that the records proposed for disposal in this Request of 13 page(s) are not now needed for the business of this agency or will not be needed after the retention periods specified; and that written concurrence from the General Accounting Office, if required under the provisions of Title 8 of the GAO Manual for Guidance of Federal Agencies, is attached.

A. GAO concurrence:  is attached,  is attached,  is attached,  is attached.  has been requested.

B. DATE <b>2/17/87</b>	C. SIGNATURE OF AGENCY REPRESENTATIVE  <b>LYNN H. COVINGTON</b>	D. TITLE <b>Director, Paperwork Management and Regulations Service</b>
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7. ITEM NO.	8. DESCRIPTION OF ITEM <i>(With Inclusive Dates or Retention Periods)</i>	9. GRS OR SUPERSEDED JOB CITATION	10. ACTION TAKEN <i>(NARS USE ONLY)</i>
	<p><u>VA MEDICAL RECORDS OF PATIENTS</u></p> <p>This request for records disposition authority covers certain VA medical records which document the medical care of individuals (veterans and non-veterans; VA beneficiaries and non-VA beneficiaries) who are treated at VA health care facilities. They include clinical records and related administrative records pertaining to the individual. The primary active medical records are referred to as the Medical Records Folder File or the Consolidated Health Record. They consist of two segments, (a) medical or clinical records and (b) administrative or correspondence records, which document episodes of medical care and benefits provided to patients by the VA. Primary records are considered inactive 3 years after the last episode of care, at which time they are converted to a Perpetual Medical Record and an Inactive Medical Record for long-term retention. Auxiliary medical records created as a result of specific medical procedures or tests, records of patient's visits, indices to these auxiliary records, etc., while consisting of separate files series for maintenance and disposition purposes, are summarized in the primary medical</p>		

39 items

7. ITEM NO	8. DESCRIPTION OF ITEM (With Inclusive Dates or Retention Periods)	9 SAMPLE OR JOB NO	10. ACTION TAKEN
	<p>records. The disposition of the primary medical records is shown in items 1 through 3; all other item numbers pertain to auxiliary medical records. References to item numbers in the current VA Department of Medicine and Surgery Records Control Schedule (RCS) 10-1 precede the title of each records series.</p> <p>This request includes certain records series that have been reappraised under the moratorium against the destruction of VA medical records which was imposed in July 1979 and for which proposed retention periods are the same as previously approved by the cited NARA job numbers. Such records are included herein to provide a comprehensive listing of VA medical records pertaining to patients and are noted by an asterick (*) in column 7, Item No.</p> <p><u>MEDICAL ADMINISTRATION SERVICE RECORDS (RCS 10-1, Section XXII)</u></p>		
1	<p>136-5 -<u>Medical Records Folder File or Consolidated Health Record.</u> This records series contains all professional and administrative material necessary to document the episodes of medical care and benefits provided to individuals by the VA health care system.</p>		
1a	<p><u>Medical Records Folder.</u> This file constitutes the active medical or clinical records segment of the Consolidated Health Record. It completely documents diagnostic examinations and definitive medical, surgical, psychiatric, and dental care or treatment rendered a patient at a VA health care facility. It contains in written and graphic form the diagnostic, treatment and sociological information compiled by various members of the medical care team who participated in the care of a patient during one or more courses of treatment. In addition, it is intended to meet the legal, administrative, teaching and research needs of the VA medical staff, and provide a means of studying and evaluating the type of care rendered. VA and other monetary benefits are sometimes decided by use of information from the Medical Records Folder.</p>	NN 165-117	

7 ITEM NO	8. DESCRIPTION OF ITEM (With Inclusive Dates or Retention Periods)	9 SAMPLE OR JOB NO	10. ACTION TAKEN
	<p>Disposition: Retain in VA health care facility along with the Administrative Records Folder until 3 years after last episode of care, then convert to a Perpetual Medical Record and an Inactive Medical Record.</p> <p>NOTE: Disposition of Dental X-ray Film which may be filed in the Medical Records Folder is in accordance with item 8a.</p>		
1b	<p><u>Administrative Records Folder (Correspondence Folder).</u> This file constitutes the active administrative records segment of the Consolidated Health Record. It contains documentation of the patient's legal eligibility for VA medical benefits and the administrative documents relating to various episodes of hospital, nursing home, domiciliary, or outpatient care furnished at VA health care facilities.</p> <p>Disposition: Retain in VA health care facility along with the Medical Records Folder until 3 years after the last episode of care, then convert to a Perpetual Medical Record and an Inactive Medical Record.</p>		
1c	<p><u>Perpetual Medical Record.</u> This record is created by extracting certain documents from the Consolidated Health Record (clinical and administrative segments) after a three year period of inactivity from the date of discharge or release of patient from the last episode of care. It contains the following basic medical and administrative records for each episode of care:</p> <ul style="list-style-type: none"> <li>° Application for medical benefits.</li> <li>° Narrative treatment summary, or equivalent.</li> <li>° Record of hospitalization, or equivalent.</li> <li>° Operation report and tissue examination report for each episode of care, if applicable.</li> <li>° Autopsy report for death case, if applicable.</li> </ul> <p>It also contains records relating to release of information, requests to amend records, records of denied access or disputes as required under the Privacy Act of 1974.</p>	NC-15-76-10	

Request for Records Disposition Authority - Continuation

JOB NO

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7. ITEM NO	8. DESCRIPTION OF ITEM (With Inclusive Dates or Retention Periods)	9 SAMPLE OR JOB NO	10 ACTION TAKEN
1d	<p>Disposition: Retain at the VA medical facility for 75 years from the date of discharge or release of the patient from the last episode of care (approx. 72 years); destroy by <del>shredding</del> <i>witness disposal</i>.</p> <p><u>Inactive Medical Record.</u> This record contains all residual material from the Consolidated Health Record that was not extracted for placement in the Perpetual Medical Record 3 years after the last episode of care. It consists of a medical/clinical records segment and an administrative/correspondence records segment.</p> <p>Disposition: Retire annually to the servicing Federal Archives and Records Center (FARC) for storage. If not recalled by the <del>accessioning</del> <i>witness disposal</i> facility for reactivation, destroy by <del>shredding</del> <i>witness disposal</i> 75 years from the date of discharge or release of the patient from the last episode of care (i.e. approx. 72 years after retirement).</p>		<p><i>OK by J. McMenamin 4-5-88 JSM</i></p> <p><i>OK J. McMenamin 4-5-88 JSM</i></p>
2	<p><u>Domiciliary Members Treatment Folder.</u> Type J medical and dental treatment records which document services rendered to a domiciliary member during their stay at a domiciliary. This records folder series was discontinued at domiciliaries on May 15, 1971, and was replaced by the Medical Records Folder series.</p>	II NNA-2568	
2a	<p>Domiciliary Members Treatment Folders on hand at domiciliaries on or after May 15, 1971.</p> <p>Disposition: Convert to Medical Records Folder and follow disposition requirements of that file series (item 1a).</p>		
2b	<p>Domiciliary Members Treatment Folders retired to Federal Archives and Records Centers (FARCs) on or after June 20, 1968.</p> <p>Disposition: Retain at FARC until recalled for reactivation and subsequently converted to a Medical Records Folder; or, destroy by <del>shredding</del> <i>witness disposal</i> 75 years from date of separation or release of members from domiciliary. <del>which is 60 years after date of transfer of folder to FARC.</del> (NOTE: Folders retired <del>to FARC</del> <i>to FARC</i> and prior years are eligible for destruction in the year 2039.) <del>or 60 years after 1979.</del></p>		<p><i>OK by J. McMenamin JSM</i></p> <p><i>for 1963 records</i></p>

7  
ITEM NO8. DESCRIPTION OF ITEM  
(With Inclusive Dates or Retention Periods)9  
SAMPLE OR  
JOB NO10.  
ACTION TAKEN

3

Domiciliary Members Correspondence Folder. All essential administrative records accumulated during member's stay at the domiciliary which document member's admission, maintenance, activities, development, treatment rehabilitation, separation or discharge. Also included are records related to disciplinary actions, leaves of absence or furloughs; correspondence between the domiciliary and welfare agencies, service groups and public officials; reports of previous hospitalization or domiciliary care, etc. This records series was discontinued at domiciliaries and was replaced by the Medical Records Folder series.

3a

Domiciliary Members Correspondence Folders on hand at domiciliaries on or after May 15, 1971.

Disposition: Convert to Administrative Records Folder (Correspondence Folder) and follow disposition requirements of that file series (item 1b).

3b

Domiciliary Members Correspondence Folders retired to Federal Archives and Records Centers (FARCs) on or after June 20, 1968.

Disposition: Retain at FARC until recalled for reactivation and subsequently converted to a Medical Records Folder; or, destroy by ~~with no disposal~~ shredding 75 years from date of separation or release of member from domiciliary, ~~which is 60 years after date of transfer of folder to FARC.~~ (NOTE: Folders retired in 1968 and prior years are eligible for destruction in the year 2039, ~~or 60 years after 1979.~~) *records*

OK g. McMenamin  
4-5-88  
TBM

for 1963 records

4

Outpatient Treatment Folder File. Folders under this records series have been established only for veterans treated for service connected and/or adjunct conditions on an outpatient basis. The file contains Medical histories and physical examinations, VA treatment and progress records, fee basis reports of medical care, VA and non-VA hospital summaries, and other medical records, including dental treatment records, mental hygiene, prosthetic and sensory aid and similar records. This folder contains professional and administrative records pertaining to outpatient services

II-NNA-  
2569

7.  
ITEM NO8. DESCRIPTION OF ITEM  
(With Inclusive Dates or Retention Periods)9.  
SAMPLE OR  
JOB NO10.  
ACTION TAKEN

rendered and are designed to give the professional staff as complete a clinical background as is possible upon which to base conclusions and determine courses of outpatient treatment and to take action and properly document such administrative actions as are necessary and required.

This records series is being phased out as a separate folder file, and new folders have not been established since October 1, 1983. The information formerly maintained under this series is now being maintained in the two active segments of the Consolidated Health Record (item 1).

4a Outpatient Treatment Folders currently on hand at VA medical facilities.

Disposition: Transfer to Consolidated Health Record and retain in VA health care facility until three years after last episode of care, then convert to a Perpetual Medical Record and an Inactive Medical Record.

NOTE: Disposition of Dental X-Ray Film which may be filed in this folder is in accordance with item 8a.

4b Outpatient Treatment Folders retired to Federal Archives and Records Centers (FARCs) on or after June 20, 1968.

Disposition: Retain at FARC until recalled for reactivation and subsequently converted to a Medical Records Folder; or, destroy by ~~with no disposal~~ shredding 75 years from date of separation or release of members from domiciliary, ~~which is 60 years after date of transfer of folder to FARC.~~ (NOTE: Folders retired in 1968, and prior years, <sup>records</sup> are eligible for destruction in the year 2039, ~~or 60 years after 1979.~~)

OK G. McMenamin  
4-5-88  
TSM

for 1963 records

5 136-7-- Patient Locator File. Locator card records containing basic identification data for each patient admitted to the health care facility for inpatient treatment. NC 15-76-10

Disposition: Retain in health care facility until patient is discharged and until administrative purposes have been served, then destroy.

7. ITEM NO	8. DESCRIPTION OF ITEM (With Inclusive Dates or Retention Periods)	9 SAMPLE OR JOB NO	10. ACTION TAKEN
6	<p><u>136-6 -Tumor Registry File (Index Card and Folder Files).</u> This file contains information on patients treated for tumors. It contains abstracts of inpatient information from the Medical Records Folder File, subsequent follow-up data (including that from private sources), and related material. This file is used for treatment purposes as well as research.</p> <p>Disposition: Retain at VA health care facility; destroy 75 years after date of last activity.</p> <p><u>DENTAL SERVICE RECORDS (RCS 10-1, Sec. XXVI)</u></p>	NC 15-76-10	
7	<p><u>160-4 -Dental Master Card.</u> Detailed summary of dental services rendered to a patient in a VA health care facility; used as a ready reference on veterans treated in the dental clinic, for budget purposes, and for compiling statistics on patients treated.</p> <p>Disposition: Destroy 3 years after date of last activity.</p>	NN 171-117	
8	<p><u>160-6 Dental X-ray Film File.</u> Intra-oral dental x-ray film, exposed.</p>	NN 171-117	
8a	<p>Dental x-rays filed in Outpatient Treatment Folder or in Medical Records Folder.</p> <p>Disposition: Retain until folder is converted to a Perpetual Medical Record and an Inactive Medical Record (3 years after last episode of care), then destroy.</p>		
8b	<p>Dental x-rays used for research and teaching purposes which are not filed in the patient's record.</p> <p>Disposition: Retain until purpose has been served or 3 years after last exposure, whichever is longer; then destroy.</p>		
8c	<p>All other original dental x-rays maintained at VA health care facilities.</p> <p>Disposition: Retain until 3 years after the date of last exposure, then destroy.</p>		
8d	<p>Facsimile reproduction of dental x-rays.</p> <p>Disposition: Destroy when purpose has been served.</p>		

7 ITEM NO	8 DESCRIPTION OF ITEM (With Inclusive Dates or Retention Periods)	9 SAMPLE OR JOB NO	10 ACTION TAKEN
	<p>NOTE 1: VA X-ray films are currently disposed of by salvaging at the VA Supply Depot under the VA Precious Metals Recovery Program.</p> <p>NOTE 2: Certain dental X-rays taken at VA health care facilities in support of veterans benefits claims are disposed of in accordance with Department of Veterans Benefits RCS VB-1.</p> <p><u>REHABILITATION MEDICINE SERVICE RECORDS</u> <u>(RCS 10-1, Sec. X)</u></p>		
9*	<p>117-1 - <u>Patient Index Card and Attendance Record File.</u> Index card and attendance records indicating patient's name, diagnosis, treatment and record of attendance in Physical Medicine and Rehabilitation Service by patients treated. Information is used for readmission purposes in the event the patient returns for treatment, and for administrative and reporting purposes.</p> <p>Disposition: Destroy 2 years after discharge of patient.</p>	351-S170	
10*	<p>117-2 - <u>Rehabilitation Medicine Patient Folder File</u> <u>Copies of various clinical records and related documents used to record treatment and services provided to patients are combined in this file upon completion of treatment.</u></p> <p>Disposition: Destroy 2 years after discharge of patient, or when no longer needed by Chief, Physical Medicine and Rehabilitation Service (unusual or exceptional cases only), whichever is later, and after record of treatment has been filed in the Consolidated Health Record.</p> <p><u>RADIOLOGY SERVICE RECORDS (RCS 10-1, Sec. VII)</u></p>	351-S310	
11*	<p>114-5 - <u>Patient Therapy File (Radiology Service).</u> Copies of treatment course records, therapy summaries, progress notes, technical factors applied and related material.</p> <p>Disposition: Destroy 10 years after last date of activity and after record of treatment has been filed in the Consolidated Health Record.</p>	NN-163-96	

Request for Records Disposition Authority - Continuation		JOB NO	PAGE OF 9 of 13
7 ITEM NO	8 DESCRIPTION OF ITEM (With Inclusive Dates or Retention Periods)	9 SAMPLE OR JOB NO	10 ACTION TAKEN
12*	<p>114-6--Patient Tumor Treatment Control Card File. Individual cards maintained alphabetically by name of patient as a tumor master record and which are used as a pathological index to and summary of patients treated; used for treatment, teaching and research purposes.</p> <p>Disposition: Destroy individual inactive cards 10 years after patient is no longer under treatment or followup program.</p>	NN-163-96	
13	<p>114-8--X-Ray Film File (General). Exposed X-ray films other than military entrance and separation X-rays, copies of interpretations filed with the X-ray films, and facsimile reproductions of X-rays maintained at VA health care facilities, except those requested by the Medical Executive Committee for use in research, teaching, special studies, etc.</p>		
13a*	<p>Veterans' X-rays.</p> <p>Disposition: Destroy 5 years after date of last exposure or 10 years after separation from military service, whichever is later, and after a report has been filed in the Consolidated Health Record.</p>	NN 170-82	
13b*	<p>Non-veteran VA beneficiary X-rays.</p> <p>Disposition: Destroy 5 years after date of last exposure.</p>	NN 170-82	
13c*	<p>VA Employee X-rays showing no active disease, to include the original copy of the interpretation.</p> <p>Disposition: Retain as a part of the Individual Employee Health Case File. Destroy <del>5</del> years after <del>last entry in case file</del>: <i>retirement to M. 60</i></p> <p><del>NOTE: Disposal of these individual employee health case files has been suspended by GSA FPMR Bulletin B-112, August 5, 1981.</del></p>	GRS 1, Item 21, c	
13d*	<p>VA Employee X-rays showing active disease.</p> <p>Disposition: Retain as a part of the Individual Employee Case File. Destroy <del>5</del> years after <del>last entry in case file</del>: <i>retirement to FRC.</i></p>	GRS 1, Item 21, c	

## Request for Records Disposition Authority - Continuation

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7. ITEM NO	8 DESCRIPTION OF ITEM (With Inclusive Dates or Retention Periods)	9. SAMPLE OR JOB NO	10. ACTION TAKEN
	<p>NOTE: <del>Disposal of these individual employee health case files has been suspended by GSA FPMR Bulletin B-112, August 5, 1981.</del></p>		
13e	<p>X-rays of non-VA beneficiaries who are not VA employees ("good samaritan" cases).</p> <p>Disposition: Destroy when 1 year old.</p>		
13f	<p>Veteran's "Interim" X-rays which were made by the military service during the former servicemember's active military service and which were subsequently transferred to VA custody.</p> <p>Disposition: Destroy 5 years after X-ray is transferred to VA custody.</p>	II NNA-1308	
13g*	<p>X-ray facsimile reproductions.</p> <p>Disposition: Destroy after purpose has been served.</p>	II NNA-1308	
13h	<p>X-rays that are unserviceable, unidentifiable, or otherwise unsuitable for diagnostic purposes because of faulty exposure or processing, cloudiness, discoloration, breaking, general deterioration, or unclear name and/or number of the patient.</p> <p>Disposition: Destroy immediately.</p>		
13i	<p>Copies of X-ray interpretations which are filed with the X-rays. (Original interpretations are filed in the Consolidated Health Record.)</p> <p>Disposition: Destroy when X-ray is destroyed.</p> <p>NOTE: VA X-ray films are currently disposed of at the VA Supply Depot by salvaging in accordance with the VA Precious Metals Recovery Program.</p>		
14*	<p>114-9 -X-Ray Film File (Teaching). Exposed X-ray films of special interest and those having exceptional teaching value.</p> <p>Disposition: Destroy after 10 years and when no longer of value for teaching and educational purposes.</p>	II NNA-1308	

Request for Records Disposition Authority - Continuation		JOB NO	PAGE OF 11 OF 13
7. ITEM NO	8 DESCRIPTION OF ITEM (With Inclusive Dates or Retention Periods)	9. SAMPLE OR JOB NO	10. ACTION TAKEN
15*	<p>114-10 -X-Ray Pathological Index File Cards indexing special and interesting roentgenological entities.</p> <p>Disposition: Destroy when no longer of medical reference value or when card is replaced.</p> <p><u>NUCLEAR MEDICINE SERVICE RECORDS (RCS 10-1, Sec. IX)</u></p>	II NNA-1308	
16	<u>Nuclear Scan Files</u>		
16a	<p>115-6 -Nuclear Scan File--General. Nuclear scans and copies of interpretations maintained for treatment purposes and not being used for purposes of teaching, active research or cooperative studies.</p> <p>Disposition: Destroy 5 years after date of latest scan in the folder and after report has been filed in the Consolidated Health Record.</p>	NCl-15-76-23 NCl-15-81-25	
16b	<p>115-9 -Nuclear Scan File--Teaching. Nuclear scans and copies of interpretations selected for teaching and educational purposes.</p> <p>Disposition: Return to Nuclear Scan File (General) for appropriate disposition when teaching purposes have been served or destroy immediately if file is more than 5 years from date of latest scan in folder.</p>	NCl-15-76-23	
16c	<p><u>Nuclear Scan File--Research and Cooperative Studies.</u> Nuclear scans and copies of interpretations selected for research and cooperative studies purposes.</p> <p>Disposition: Return to Nuclear Scan File (General) for appropriate disposition when purposes have been served or destroy immediately if file is more than 5 years from date of latest scan in folder.</p>		
17*	<p>115-7 -Nuclear Scan Alphabetical Index File. An alphabetical cross index to nuclear scans which are filed numerically by social security numbers; annotated to reflect removal from Nuclear Scan File--General and placed in Teaching or Research and Cooperative Studies files.</p> <p>Disposition: Destroy when related nuclear scans are destroyed.</p>	NCl-15-76-23	

## Request for Records Disposition Authority - Continuation

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7 ITEM NO	8. DESCRIPTION OF ITEM (With Inclusive Dates or Retention Periods)	9 SAMPLE OR JOB NO	10. ACTION TAKEN
18*	<p>115-8 -<u>Nuclear Scan Pathological Index File.</u> Cards indexing special interest scans, normal and abnormal, for medical reference purposes.</p> <p>Disposition: Destroy when no longer of medical reference value or when card is replaced.</p>	NC1-15-76-23	
19*	<p>115-10-<u>Patient Therapy File.</u> Records of course of treatment, therapy summaries, progress notes, therapeutic doses of radiopharmaceuticals received, and technical factors applied.</p> <p>Disposition: Destroy 10 years after last episode of treatment or follow-up care and after report has been filed in the patient's Consolidated Health Record.</p> <p><u>LABORATORY SERVICE RECORDS (RCS 10-1, Sec.VII)</u></p>	NC1-15-76-23	
20*	<p>113-6 -<u>Blood Transfusion Request and Record File.</u> Copies of the Clinical Record-Blood Transfusion indicating blood grouping, typing and compatibility tests.</p> <p>Disposition: Destroy after 5 years and after information has been recorded in the patient's Consolidated Health Record.</p>	NN-171-54	
21	<p>113-9 -<u>Laboratory Reports File</u></p> <p>21a* Patient Section. Copies of clinical record-laboratory reports on patients.</p> <p>Disposition: Destroy 30 days after the end of the reporting period and after original report has been filed in the patient's Consolidated Health Record.</p> <p>21b* Other than patient section. Original and copies of clinical record-laboratory reports used for examination of individuals other than patients, such as blood donors.</p> <p>Disposition: Destroy after 6 months.</p>		
22*	<p>113-11 -<u>Tissue Examination Record File.</u> Copies of tissue examinations, maintained in numerical order.</p>	NC-15-76-4	

**Request for Records Disposition Authority - Continuation**

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7  
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8. DESCRIPTION OF ITEM  
(With Inclusive Dates or Retention Periods)

9  
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Disposition: Destroy when 25 years old and after report has been filed in the patient's Consolidated Health Record.