Ohio Administrative Code

Rule 3701-22-29 Record keeping.

Effective: August 31, 2025

(A) Medical record. Each maternity unit or newborn care nursery will maintain a medical record for each patient that documents, in a timely manner and in accordance with acceptable standards of practice, the patient's needs and assessments, and services rendered. Each medical record will be legible and readily accessible to staff for use in the ordinary course of treatment.

(B) Each maternity unit will maintain delivery logs that includes the following, if known at the time of delivery:

(1) Maternal name;

(2) Admission date;

(3) Estimated date of confinement;

(4) Membrane rupture date and time;

(5) Type of anesthesia, to include:

(a) Epidural;

(b) General;

(c) Local; or

(d) Spinal;

(6) Type of delivery, to include:

(a) Cesarean section;

(b) Forcep;

(c) Trial of labor after cesarean;

(d) Vaginal; or

(e) Vacuum;

(7) Delivery date and time;

(8) Newborn's weight;

(9) Apgars;

(10) Gestational age; and

(11) Complications, if any, to include:

(a) Delivery and postpartum problems;

(b) Diabetes (gestational);

(c) Emergency cesarean section;

(d) Hemorrhage;

(e) Known fetal anomalies;

(f) Placenta previa;

(g) Placental abruption;

(h) Preeclampsia;

(i) Gestational hypertension; or

(j) Uterine rupture.

(C) A provider may keep the delivery log set forth in paragraph (B) of this rule on an electronic system that makes the necessary information readily accessible to the director.

(D) Each maternity unit or newborn care nursery will not disclose individual medical records except as authorized by the patient, the parent or guardian of an infant or minor, or as allowed by state and federal laws and regulations, including but not limited to the provisions of this chapter of the Administrative Code.

(E) Each maternity unit or newborn care nursery will:

(1) Systematically review records for conformance with acceptable standards of practice and the standards established by this chapter of the Administrative Code;

(2) Maintain an adequate medical record-keeping system and take appropriate measures to ensure the confidentiality of patient medical records;

(3) Maintain fetal monitoring strips in a format that maintains the record for the period of time mandated for medical record retention; and

(4) Maintain medical records as necessary to verify the information and reports obligated by statute or regulation for five years from the date of discharge.