DA 2019-008

Patient Information Retention and Disposal Schedule for the WA health system (PIRDS)

DA Type: Functional

Patient Information Retention and Disposal Schedule for the WA health system (PIRDS)

Disposal Authority No	2019-008

Disposal Authority Type	Functional

Organisation/s	Department of Health

Disposal Authority Scope	Fully revised Retention and Disposal Schedule for Patient Information held by Public Health Care Facilities, to supersede RD 2014-001.

Disposal Authority Status	Approved by SRC

Status Date	19/05/2022

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List of Functions and Activities covered

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INTRODUCTION

1. ABOUT THIS SCHEDULE

1.1 Important note

This Retention and Disposal Schedule (Schedule) is to be used in combination with the State Records Office publication *General Disposal Authority for State Government Information* which covers records of activities / categories that are common across State government.

The State Records Office guideline *Records Retention and Disposal Instructions* will be consulted before any disposal of records is conducted, whether as part of a formal / regular disposal program or on an ad hoc basis.

1.1.1 Records relevant to actual or alleged child sexual abuse and other records relating to children

The final report of the Commonwealth Royal Commission into Institutional Responses to Child Sexual Abuse, released on 15 December 2017, contains several recommendations concerning recordkeeping by government organizations undertaking child-related functions or activities.

Organizations must be mindful of records that document, or may otherwise be relevant to, actual or alleged incidents of child sexual abuse, and the care, supervision, education and treatment of children by government employees, contractors, volunteers and outsourced service providers in contact with children. Such records may be subject to specific retention instructions as issued by the State Records Office.

1.1.2 Records relating to Aboriginal people

Health care facilities and agencies must retain Aboriginal patient records indefinitely for patients and clients with a date of birth prior to and including 1970. In addition to this, Aboriginal patient records created by remote clinics in the Kimberly, Pilbara, Goldfields and Midwest health regions must also be kept indefinitely, regardless of date of birth.

Both types of Aboriginal records outlined above, excludes Case Management Program records. This is due to their complex nature and sensitivity and may be destroyed upon fulfillment of specific minimum retention periods.

1.1.3 Records relating to Research

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The WA health system have determined that research records relating to patient information must be kept as per applicable research activities within the Western Australian University Sector Disposal Authority both current (SD2011011) and future version. Further information available in section 3.12 of this Schedule.

1.2 Organisation background

In 2016, the *Health Services Act 2016* was enacted and changes were made to the WA health system. The WA health system now consists of the Department of Health (as System Manager) and Health Service Providers (North Metropolitan Health Service, South Metropolitan Health Service, East Metropolitan Health Service, WA Country Health Service, Child and Adolescent Health Service, Health Support Services, PathWest and Quadriplegic Centre).

The Western Australian health system provides safe, high-quality health care to all Western Australians. The WA health system is reliant on access to relevant and accurate patient medical records for the effective delivery of patient care. This information underpins the delivery of evidence based health care. Information has most value when it is accurate, up-to-date and accessible when it is needed. An important part of an effective records management service is determining how long to retain information relating to patients. A retention and disposal schedule ensures records are kept for as long as legally and operationally required and the obsolete records are disposed of in a systematic and controlled way.

1.3 Purpose of this Schedule

This Schedule has been developed to form part of the Recordkeeping Plans of the WA health system, as required under section 16(3)(a-c) of the *State Records Act 2000*.

The objectives of this Schedule are to:

- Identify all patient records of the WA health system entities;
- Identify which patient records are required for permanent retention as State archives and which patient records can be destroyed; and

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- Establish retention periods for patient records that will be destroyed so that they are kept for appropriate periods to satisfy legal, business or other requirements.

1.4 Scope and implementation of this Schedule

This Schedule covers patient records within all health care facilities, past and present, within the WA health system. The Schedule will also be used for sentencing patient records of government organisations established for the purpose of providing mental health services.

This Schedule supersedes Patient Information Retention and Disposal Schedule Version 4, 2014. Patient records already sentenced under Patient information Retention and Disposal Schedule Version 4, 2014 which are still in the custody of the WA health system will be re-sentenced as necessary in accordance with this Schedule.

This Schedule applies to patient records in all formats.

Before any patient records covered in this Schedule are destroyed or transferred to the State Records Office as State archives, they will be reviewed by the relevant delegated authority.

The value of patient records may change over time. In assessing patient records that have reached their minimum retention period and are due for destruction, officers should consider those that may have potential business or historical value, for ongoing retention or archiving if warranted. Any patient records due for destruction that on re-assessment may have archival value should be referred to the State Records Office for further evaluation.

1.5 Investigations, inquiries and Freedom of Information

If an Investigation or Inquiry is in progress (or likely or imminent), or if a request for access to information under the *Freedom of Information Act 1992* has been lodged, all records relevant or subject to the Investigation / Inquiry / FOI request must be identified and retained until the action and any subsequent actions are completed. This applies regardless of whether the patient records in question are due for destruction.

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1.6 Review of this Schedule

Authorised employees of the WA health system will review the structure, coverage and content of this Schedule within five years of its approval. The WA health system will provide a report to the State Records Office of its review findings.

Any proposed revisions / amendments to this Schedule, or any intention to prepare a new Schedule to replace this one, will be discussed with the State Records Office prior to such activity commencing.

2. SPECIFIC MATTERS

2.1 "Significant" records

In this Schedule, each disposal class has usually been assigned one disposal action (e.g. "Required as State archives" or "Destroy").

If a disposal class contains records of both archival and non-archival value, two disposal actions have been assigned and:

- the term "Significant" has been used to identify records of archival value
- the term "Other" has been used to identify records of non-archival value.

In such cases, the criteria for identifying which records are "Significant" are that the records document matters which:

- relates to genetic information that offers insight into the potential of acquiring a condition, or serves as an explanation for a disease (including the likelihood that offspring will inherit a related trait or condition)
- concerns diagnoses that are controversial, new or rare
- concerns treatment or diagnostic interventions that are considered innovative or controversial
- concerns diagnoses and/or treatment that are attracting class action litigation
- relates to controversial matters

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- relates to major obligations or liabilities of health care facilities and/or the State
- relates to matters that are attracting community-wide interest
- otherwise (significantly) impacts or affects the health care facility's functions or operations.

2.2 Archives not transferred to the State Records Office

The WA health system intends to transfer all State archives to the SRO, except those State archives that need to be held in electronic form. For example, digitised records and the electronic patient master indexes held in patient administration systems must be maintained and preserved by WA health system (unless they can be suitably printed into hard copy form). The patient administration systems that is currently operational within the WA health system are Web Patient Administration System (webPAS) and HCARe. TOPAS is being maintained as a legacy system.

The WA health system intends to maintain and preserve records that have been digitised or are born digital. This includes ensuring records are accessible for as long as they are required under the Schedule, as well as ensuring that digital and born digital records are migrated and preserved across systems to retain the integrity and authenticity of the records.

2.3 Restricted access archives

A restricted access archive is *"a State archive that is a government record and to which access is restricted until it is of a certain age" (State Records Act 2000, sect. 3)*. Part 6 of the *State Records Act 2000* provides for the restriction of certain categories of State archives.

Patient information contained within State archives (permanent value records) is accessible to the public after a 100-year restricted access period that applies from the date of last documentation on the record. Restricted access archives are identified within this Schedule and until the restricted access period for these records expires, access may be granted by the facility which created the records, regardless of whether the record is in the custody of the facility or the SRO. Access to these archives is subject to confidentiality of the records not being breached and in accordance with privacy requirements.

The 100-year period will commence from the date of last documentation and not the date that the record is transferred to the SRO. The 100-year period will apply to records created on or after 1 January 1920. Records created prior to January 1920 will remain open to access.

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After 100-years, State archives will be open to the public. Where a public health care facility is no longer operating and the records are not in the custody of the SRO, the Department will manage requests for access to restricted access records.

3. DEFINITIONS

3.1 Definitions of terms

Accessible able to read or interpret as having meaning.

Age Minimum is the minimum age at which the record can be sentenced.

Archive in Agency an electronic record that will be retained permanently by the WA health system as a State archive.

Assigned Retention Period is the amount of years a record is required to be kept before they are able to be destroyed.

Authentic means the digitised version replicates the attributes of the source record and can be proven to be what it purports to be.

Born digital record refer to Electronic record.

Class of record describes the type of record, its contents and the medium on which data is recorded and stored.

Client refer to Patient record.

Client record refer to Patient record.

Custody *means* the minimum retention period for which records are to be kept prior to their disposal. The Custody statement includes the disposal trigger that begins the retention period.

Date of death where date of death is known, apply the applicable sentencing as per the schedule. Where date of death is unknown, destroy 120 years from date of birth.

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Date of last documentation refers to the last time the record had documentation added for purposes that directly related to the care of the patient. This includes documentation for:

- a patient admission, including Hospital in the Home
- a non-admitted patient service, including emergency, outpatient, community health or community-based treatment programs.

Destroy *applies to* records identified as having temporary value and which will be destroyed once their retention period has expired.

Destroy when reference ceases indicates that a patient record may be destroyed once reference is no longer necessary. This is an instruction which may be applied at the health care facility discretion only within the limits of the schedule. For example, if a facility no longer has an identified need to access a particular set of patient records, they may be destroyed at the facility discretion.

Digitisation refers to the creation of digital images from paper documents by such means as scanning.

Digitised records include health records produced by digitisation. Digitised health record and scanned health record are synonymous in this document.

Disposal Action *means* the final disposition for records once their retention period has expired. The main disposal actions are "Required as State archives" and "Destroy".

Electronic Records refers to data created, captured, recorded, stored and conveyed on any digital storage medium, such as a computer and only originate in digital format (e.g. email, database records, e-forms).

Index No. the reference number assigned to each individual record or class of records.

Original record a record that precedes all others in time and is not derived, copied or translated from another record. Original records may be paper-based or electronic.

Patient (Client) an individual, family or group that has received, is receiving or is scheduled to receive a health service or health services from the Western Australian government health sector. A patient may be considered as a single identifiable unit in this context.

Patient record a documented account, in any format, of a client's/patient's health, illness and treatment during each visit or stay at a health service.

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Psychiatric record any record of a patient who has received treatment for a psychiatric episode or episodes of care at a mental health care facility, outpatient clinic or community mental health service.

Reference indicates that the record has been used or accessed for any reason.

Remote communities geographic locations bound by physical or legal boundaries and inhabited predominantly by Aboriginal people for whom the WA health system provides healthcare services.

Required as State archives *applies to* records identified as having permanent value. State archives are to be transferred to the State Records Office once their retention period has expired (unless the State Records Commission has given approval for the organisation to retain such records).

Restricted access refers to State archives in which access is restricted until they are of a certain age. All records identified in this Schedule as being State archives are restricted access archives.

Retain in agency the disposal action for a class of records identified as NOT being State archives but which are to be retained permanently in-house by the agency for ongoing reference purposes.

Royal Commission is an investigation, independent of government, into a matter of public importance. Royal commissions have broad powers to hold public hearings, call witnesses under oath and compel evidence.

Source record in this context means a paper-based patient record where a digitised version has been created. The source record is the systematic documentation of a single patient's medical history and includes, but is not limited to, notes captured at examination, treatment plans, medication charts, correspondence between treating clinicians and diagnostic reports. This information is documented, in the first instance, on paper and filed in the patient's medical record.

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No	Function/Activity	Description	Disposal Action	Custody
1	**Individual patient records**	Refers to records relating to individual inpatients/discharged, outpatients, deceased patients, psychiatric patients and emergency patients in and associated with acute hospitals. Note: excludes Aboriginal patient records as per Introduction 1.1.2		
1.1	**Records of discharged patients and outpatients**	Refers to patient records, including records: • held by individual departments retained separately from the main hospital record (e.g. Departmental records) • of discharged patients from extend care facilities, including outpatients services (day hospitals, day centres and domiciliary care services) • State run regional aged care facilities and hostels • that relate to legal claims whether filed within the individual patient record or another information system • that are in a microform format.	Destroy	Retain 60 years after last attendance or date of last documentation, then Destroy.
1.2	**Records of deceased patients**	Refers to records of patients that have died while in hospital, or who are known to be deceased.	Destroy	Retain 60 years after date of death or date of last documentation,

No	Function/Activity	Description	Disposal Action	Custody
Individual patient records				
		This includes records: • held by individual departments retained separately from the main hospital record (e.g. Departmental records) • of deceased patients within extend care facilities • that are in a microform format.		then Destroy.
1.3	**Emergency department records**	Includes outpatient records of any public hospital that does not have a formally constituted outpatient department and that files its outpatient notes separately from the records identified in Index No. 1.1 and 1.2. Includes triage records, nursing post records, and documentation concerning patients who were dead on arrival. Information includes the date and time of arrival, description of significant clinical, laboratory and radiological findings, details of treatment, time of discharge and attending medical officer. Where Emergency records are filed within records identified in Index No. 1.1 and 1.2, sentence according to these record classes. Also includes Emergency records that are in a microform format.	Destroy	Retain 60 years after last attendance or date of last documentation, then Destroy.
1.4	**Psychiatric records**	Refers to psychiatric records at a mental health care	Destroy	Retain 7 years after

No	Function/Activity	Description	Disposal Action	Custody
Individual patient records				
		facility, outpatient clinic or community mental health service.		date of death or post mortem provided the patient has attained the age of 25 years, then Destroy.
1.5	**Duplicates**	Refers to paper duplicates of records identified in Index No. 1.1, 1.2, 1.3 or 1.4.	Destroy	Retain until reference use ceases, then Destroy.
2	**Patient indexes, registers and lists**	Patient indexes, registers and lists are mostly contain within webPAS and HCARe with TOPAS currently being maintained as a legacy system. The last two years of TOPAS was transferred to webPAS. Paper or card versions may still exist and must be treated accordingly. Note: excludes Aboriginal patient records as per Introduction 1.1.2		
2.1	**Patient index**	**Patient master index** - records the names of patients who have been admitted to a public hospital, extended care unit or community health centre. **Disease and operation index** - for each disease/condition and operation or procedure code.		
2.1.1		Paper forms of the Patient master index and Disease and operation index. These records are restricted access archives	Required as State archives	Retain 25 years after reference ceases, then transfer to the SRO.

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No	Function/Activity	Description	Disposal Action	Custody
Patient indexes, registers a				
2.1.2		Electronic Patient master index (i.e. webPAS, TOPAS, HCARe) and Disease and operation index These records are restricted access archives	Required as State archives	Archive in agency
2.2	**Patient registers**	**Number register** - used to list the unit record number in numerical order and as each number is issued, records of the name of the patient to whom that number has been issued. **Admission and/or discharge register** - lists in date order, each patient admitted and discharged. Admission and discharge register may be separated or combined. **Emergency department register** - contains various emergency department information including patient demographics, date and time of attendance and reason for attendance. **Labour ward (birth) register** - lists in date order each birth occurring in the hospital. **Death register** - lists in date order each death occurring in the facility. **Operations or theatre register** - lists in date order each operation or procedure carried out in the theatre.		
2.2.1		Paper forms of the patient registers	Required as State archives	Retain 25 years after reference ceases, then

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No	Function/Activity	Description	Disposal Action	Custody
Patient indexes, registers a				
		These records are restricted access archives		transfer to SRO.
2.2.2		Electronic form of the patient registers These records are restricted access archives	Required as State archives	Archive in agency
2.3	**Patient lists**	Applies to outpatient lists, outpatient attendance lists, appointment book or sheets, death list, operation or theatre lists or schedule. **Ward register** - This lists, in date order, reception of each inpatient into the ward. Information can be paper-based or electronic within a patient administration system and will include date of reception and name of patient. **Physicians index** - for each medical practitioner with admitting rights, this index (electronic or manual) records the inpatient attended by that practitioner during the period covered by the index.	Destroy.	Retain until reference use ceases, then Destroy.
2.4	**Bed return or daily inpatient census**	This records the number of inpatients present in the ward at the census time and lists any inpatients who have been admitted or transferred in since the previous census and any patients who have been discharged, transferred out or deceased since the previous census time. Information can be paper-based or electronic within a patient administration system.	Destroy	Retain 10 years after date of census record, then Destroy.
2.5	**Medical certificate issue book**	This book contains the medical certificate issued by clinical staff, with the original going to the patient	Destroy	Retain 10 years after the last certificate in

No	Function/Activity	Description	Disposal Action	Custody
Special categories of indivi				
		and the duplicate staying in the book. The booklet is a duplicate system with the original being given to the patient for their employee, education facility or Centrelink and the duplicate stays in the booklet.		the booklet is issued, then Destroy.
3	**Special categories of individual patient records**	If records under these categories are within the individual patient record (section 1), then sentencing should align with that record, unless the special category is longer. Note: excludes Aboriginal patient records as per Introduction 1.1.2		
3.1	**Adoption records**	This class refers to records concerning the adoption of individuals, encompassing patient information relating to the act of adoption. These records are restricted access archives.	Required as State archives	Retain 25 years after reference use ceases, then transfer to the SRO.
3.2	**Aged care assessments**	Home and Community Care aged care assessments	Destroy	Retain in accordance with 1.1, 1.2, 1.3 or 1.4, then Destroy
3.3	**BreastScreen WA program**	Refers to screening images created by BreastScreen WA only. Retain the images from the last three episodes and any images taken in the last 7 years. These two variables are independent of each other.	Destroy	Retain 7 years after date of creation of images provided the last three screening images are retained for each client, then Destroy.

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No	Function/Activity	Description	Disposal Action	Custody
Special categories of indivi				
3.4	**Case management program records**	Case Management Program (CMP) Records are temporary value records containing sensitive and confidential information. CMP records may be destroyed upon fulfillment of the minimum retention period, **regardless of Aboriginal status**.		
3.4.1		All information originating in the electronic system/application.	Destroy	Retain 7 years after case is concluded/closed, then Destroy.
3.4.2		All paper correspondence/reports both internal and external created outside the electronic record.	Destroy	Retain 7 years after case is concluded/closed, then Destroy.
3.4.3		All paper records printed/extracted from the electronic record. Excludes all correspondence/reports, both internal and external, not originating from the electronic record.	Destroy	Retain 3 years after case is concluded/closed, then Destroy.
3.4.4	**Case Management Program Register**	The register is held in electronic form and includes a list of all clients, their registration details and the period for which the CMP has contact with them. These records are restricted access archives.	Required as State archives	Archive in agency
3.5	**COVID-19**			
3.5.1		Refers to paper records of patients diagnosed with COVID-19.	Required as State archives	Retain 25 years after reference use ceases, then transfer to the

No	Function/Activity	Description	Disposal Action	Custody
Special categories of indivi				
		These records are restricted access archives.		SRO.
3.5.2		Refers to electronic records of patients diagnosed with COVID-19. These records are restricted access archives.	Required as State archives	Archive in agency
3.6	**DonateWest records**	DonateWest records include case notes, operation reports, consent documentation, pathology results and correspondence relating to organ and tissue donors in WA.	Destroy	Retain 75 years after date of death, then Destroy.
3.7	**EEG, ECG, EMG and CTG recordings**	Electroencephalography (EEG), Electrocardiogram (ECG) and Electromyography (EMG) recordings and audio-visual components. Cardiotocography (CTG) recordings and printouts. Thermal paper recordings must be photocopied and retained within the patient record. The original can then be destroyed. Full recording should be retained.	Destroy	Retain in accordance with 1.1, 1.2, 1.3 or 1.4, then Destroy.
3.8	**Individuals that have not attended a Health Care facility as a patient/client**	This category applies to documents received by a health care facility about individuals that have not subsequently attended as a patient/client and are not on an active waiting list.	Destroy	Retain 1 year after date of receipt of document, then Destroy.
3.9	**In vitro fertilisation records and artificial**			

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No	Function/Activity	Description	Disposal Action	Custody
Special categories of indivi				
	insemination register			
3.9.1		Individual patient records of each person or family unit which include consent to In Vitro Fertilisation (IVF) or Artificial Insemination (AI), and use of semen, ova or embryos and the withdrawal of consent for such processes. These records are restricted access archives.	Required as State archives	Retain 25 years after reference use ceases, then transfer to the SRO.
3.9.2		Paper registers of patients that have received or are receiving IVF and AI treatment from public health care facilities. These records are restricted access archives.	Required as State archives	Retain 25 years after reference use ceases, then transfer to the SRO.
3.9.3		Electronic registers may be held within the WA health system's patient administration systems (i.e. webPAS). These records are restricted access archives.	Required as State archives	Archive in agency
3.10	**Patient health information uploads**	Refers to health information uploaded to a WA health system database via various mobile apps by the consenting patient.	Destroy	Retain 60 years after date of last upload, then Destroy.
3.11	**Poisons information centre records (PM238)**	Refers to the Poisons Information Centre Call Record (PM238) where documentation is maintained separately from the hospital patient record.	Destroy	Retain 7 years after last official contact between the facility and patient, including access on

No	Function/Activity	Description	Disposal Action	Custody
Special categories of indivi				
		Where the document(s) are filed in the individual patient record, dispose in accordance with appropriate record classes refer to Index No. 1.1, 1.2, 1.3, 1.4		behalf of the patient provided the patient has attained the age of 25 years, then Destroy.
3.12	**Research**	The following research records must be kept as per the Western Australian University Sector Disposal Authority both current (SD2011011) and future versions. Bio-safety Conducting research Dissemination Data Analysis and Results Ethics Clearance Grant Administration Licensing Methodology Reporting Research Facilities and Support Specimen Management		

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No	Function/Activity	Description	Disposal Action	Custody
Special categories of indivi				
3.13	**Sexual assault records**	Refers to the records of Sexual Assault Referral Clinics where documentation is maintained separately from the individual patient record. Where the documents are filed in the individual patient record, dispose in accordance with appropriate record classes refer to Index No. 1.1 1.2, 1.3, 1.4.	Destroy	Retain 60 years after date of last documentation, then Destroy.
3.14	**Telehealth records**	Refers to the Telehealth records that have not been stored within the individual patient record. Telehealth records that are stored within the individual patient record, dispose in accordance to 1.2, 1.2, 1.3, 1.4.	Destroy	Retain 60 years after date of last documentation, then Destroy.
3.15	**Voluntary Assisted Dying**			
3.15.1		Refers to paper records of patients that have received voluntary assisted dying as an admitted patient. These records are restricted access archives.	Required as State archives	Retain 25 years after reference use ceases, then transfer to the SRO.
3.15.2		Refers to electronic records of patients that have received voluntary assisted dying as an admitted patient. These records are restricted access archives.	Required as State archives	Archive in agency

No	Function/Activity	Description	Disposal Action	Custody
Pathology, laboratory record				
4	**Pathology, laboratory records and diagnostic material**	Sentences are those specified in the National Pathology Accreditation Advisory Council's (NPAAC) *Requirements for the Retention of Laboratory Records and Diagnostic Material* except for 4.1.1, 4.1.5, 4.4.1, 4.10, 4.10.1, 4.10.2, 4.10.3. These guidelines should be consulted for further details or clarification. All reports and registers in this part may exist as a paper-based record, or be held electronically within the Laboratory Information System (LIS).		
4.1	**General minimum requirements**			
4.1.1	**Specimen registers**	• Refers to registers which record specimens collected or received. • Registers used to locate specimens, films, reports, blocks, slides and cultures.	Destroy	Retain 30 years after date of entry into register, then Destroy.
4.1.2	**Dr's request & analysis records**	Referring doctors request, laboratory records such as records of analysis, calculations and observations from which the result is derived.	Destroy	Retain 4 years after date of examination, then Destroy.
4.1.3	**Digital images**	Digital images or graphical output used in diagnosis, unless otherwise specified under the separate disciplines given 4.3.6.	Destroy	Retain 4 years after date of examination, then Destroy.
4.1.4	**Specimens**	All specimens unless otherwise specified at 4.11.1 and under the separate disciplines given in 4.2.4, 4.2.5, 4.2.6, 4.2.7.3, 4.3.2, 4.3.3, 4.3.4, 4.3.5, 4.4.1, 4.5.2.3, 4.5.4.1, 4.5.4.2, 4.5.5.1, 4.5.6.1,	Destroy	Retain 7 days from date of receipt or until 2 days after the final report is issued

No	Function/Activity	Description	Disposal Action	Custody
Pathology, laboratory record				
		4.6.2, 4.6.3, 4.6.4, 4.8.1, 4.9.3.1, 4.9.3.2, 4.9.4, 4.9.5.1, 4.9.5.2.		(whichever date is later), then Destroy.
4.1.5	**Original report**	The original report including non-coronial and non-forensic autopsy and post-mortem reports are filed in the individual patient record. If a cumulative reporting system is used, the most recent copy of the report should be filed in the individual patient record and sentenced accordingly. Previous copies of the cumulative report are considered copies of the report and sentence according to index 4.1.6.	Destroy	Retain in accordance with Index number 1.2 for originals
4.1.6	**Copy of report**	Copy of original report, or ability to reprint the information of an original report unless a longer period is specified as in 4.4.1, 4.5.1.1, 4.5.1.2..	Destroy	Retain 10 years after date of examination or 7 years provided the patient has attained the age of 25 (whichever is greater), then Destroy.
4.1.7	**Fertility analysis**	Semen for fertility analysis.	Destroy	Retain 3 days from date of issue of report for the purpose of identification and traceability noting that repeat testing may not be technically viable after 1 day, then Destroy.
4.2	**Anatomical pathology**			

No	Function/Activity	Description	Disposal Action	Custody
Pathology, laboratory record				
4.2.1	**Copy of Reports**	Copy of original report, or ability to reprint the information of an original report.	Destroy	Retain 10 years after date of examination or 7 years provided the patient has attained the age of 25 (whichever is greater), then Destroy.
4.2.2	**Slides**			
4.2.2.1		Sections of fixed tissue preserved in mounting medium.	Destroy	Retain 10 years after date of examination, then Destroy.
4.2.2.2		Sections of fixed tissue assessed by FISH (fluorescence in situ hybridisation).	Destroy	Retain 6 months after date of examination, then Destroy.
4.2.2.3		Sections of unstained, fixed tissue not in permanent mounting medium (unstained spares).	Destroy	Retain 1 month after date of examination, then Destroy.
4.2.2.4		Sections of unfixed tissue not in permanent mounting medium (including immunofluorescence slides).	Destroy	Retain 7 days from date of receipt or until 2 days after the final report is issued (whichever date is later), then Destroy.
4.2.3	**Blocks**	Tissue embedded in paraffin wax or any other permanent embedding medium, including for ultrastructural study.	Destroy	Retain 10 years after date of examination or 7 years provided the patient has attained the

No	Function/Activity	Description	Disposal Action	Custody
Pathology, laboratory record				
				age of 25 (whichever is the greater), then Destroy.
4.2.4	**Frozen section specimens**	Specimens for intra-operative frozen section diagnosis: • the original sections used for diagnosis, preserved on slides in permanent mounting medium • residual tissue from which the frozen sections were prepared, embedded in paraffin blocks • all other blocks of paraffin-embedded tissue from the same specimen/s from which tissue has been selected for frozen section examination.	Destroy	Retain 10 years after date of examination or 7 years provided the patient has attained the age of 25 (whichever is the greater), then Destroy.
4.2.5	**Frozen tissue blocks**	Frozen tissue blocks including specimens for immunofluorescence studies.	Destroy	Retain 1 month after date of examination at -70 degrees celsius or lower, then Destroy.
4.2.6	**Residual tissue**	• Containers with no residual tissue. • Unblocked wet tissue from specimens removed at surgery.	Destroy	Retain 1 month after date of issue of report, then Destroy.
4.2.7	**Non-coronial autopsy**			
4.2.7.1		Autopsy or post mortem reports: Originals; the	Destroy	Retain in accordance

No	Function/Activity	Description	Disposal Action	Custody
Pathology, laboratory record				
		original diagnostic report is filed in the individual patient record and sentenced accordingly. **Note** Forensic and medico-legal autopsy reports must be retained indefinitely as per 4.4.1.		with Index number 1.2 for originals, then Destroy.
4.2.7.2		Registers, report duplicate, blocks and slides, records of tissue and organ disposal.	Destroy	Retain 10 years after date of autopsy, then Destroy.
4.2.7.3		Unblocked Tissue from histological specimens retained at autopsy. Organs retained at autopsy with consent. **Note** Limitations relating to specimen retention may be agreed upon with the deceased's next-of-kin (or family) under the *Coroners Act 1996* for coronal (forensic and medico-legal) autopsies, and the *Human Tissue and Transplant Act 1982* for non-coronal autopsies.	Destroy	Retain 3 months after date of issue of report, unless limitation(s) is imposed, then Destroy.
4.3	**Cytology**			
4.3.1	**Copy of report**	Copy of original report or ability to reprint the information of an original report.	Destroy	Retain 10 years after date of examination or 7 years provided the patient has attained the age of 25 (whichever is the greater), then Destroy.

No	Function/Activity	Description	Disposal Action	Custody
Pathology, laboratory record				
4.3.2	**Non-Gynae, FNA slides and blocks**	Exfoliative non-gynaecological cytology and fine needle aspiration (FNA) slides and cell blocks.	Destroy	Retain 10 years after date of examination or 7 years provided the patient has attained the age of 25 (whichever is the greater), then Destroy.
4.3.3	**Gynaecological slides**	Gynaecological (cervical) cytology slides.	Destroy	Retain 10 years after date of examination, then Destroy.
4.3.4	**Residual fluid specimens**	Residual specimens of sputum, urine and other body fluids following preparation of cytology slides.	Destroy	Retain 7 days from date of receipt or until 2 days after the final report is issued (whichever date is later), then Destroy.
4.3.5	**Specimens in liquid based fixative**	Specimens received in liquid based fixative.	Destroy	Retain 1 month after date of validation of the report, then Destroy.
4.3.6	**Digital images**	Digital images used for diagnostic analysis e.g. semi-automated pap screening images.	Destroy	Retain 6 years after date of examination, then Destroy.
4.4	**Forensic pathology**			
4.4.1	**Forensic and medico-legal autopsy**	• Registers, report duplicate, blocks and slides, records of tissue and organ disposal, gross	Retain in agency	Retain in line with NPAAC guidelines

No	Function/Activity	Description	Disposal Action	Custody
Pathology, laboratory record				
		photographs, or • Unblocked tissue from histological samples retained at autopsy, or • Organs retained at autopsy with consent, or • Body fluids and tissues for toxicology, or • Representative tissue suitable for DNA analysis.		
4.5	**Genetics (including biochemical genetics, cytogenetics, molecular genetics and newborn screening**			
4.5.1	**Copy of report**			
4.5.1.1		Copy of original report, or ability to reprint the information content of an original report for Constitutional genetic testing.	Retain in agency	Retain in line with NPAAC guidelines
4.5.1.2		Copy of original report, or ability to reprint the information content of an original report for Somatic genetic testing.	Destroy	Retain 10 years after date of examination or 7 years provided the patient has attained the age of 25 (whichever is the greater), then Destroy.

No	Function/Activity	Description	Disposal Action	Custody
Pathology, laboratory record				
4.5.2	**Cytogenetics**			
4.5.2.1		• Analysis records/karyotypes/digital images including FISH images. • Stained microscope slides in permanent mounting medium.	Destroy	Retain 4 years after date of examination, then Destroy.
4.5.2.2		Fixed chromosome cell suspension or FISH slides.	Destroy	Retain 6 months after date of examination, then Destroy.
4.5.2.3		Original specimens and containers.	Destroy	Retain 1 month from date of issue of report, then Destroy.
4.5.3	**Cytogenetics/biochemical genetics/molecular genetics**			
4.5.3.1		Tissue cultures/cell culture lines • Rare clinically significant variants.	Retain in agency	Retain in line with NPAAC guidelines
4.5.3.2		Tissue cultures/cell culture lines • Common clinically significant variants or clinically non-significant.	Destroy	Retain 7 days from date of receipt or until 2 days after the final report is issued (whichever date is later), then Destroy.

No	Function/Activity	Description	Disposal Action	Custody
Pathology, laboratory record				
4.5.4	**Biochemical genetics**			
4.5.4.1		Specimens of plasma, serum and urine • Original container.	Destroy	Retain 7 days after date of examination, then Destroy.
4.5.4.2		Specimens of plasma, serum and urine • Analytic aliquot.	Destroy	Retain 3 months from date of issue of report, then Destroy.
4.5.5	**Neonatal screening**			
4.5.5.1		Dried blood spot • Specimen (Guthrie cards).	Destroy	Retain 2 years after date of examination, then Destroy.
4.5.5.2		Dried blood spot • Records.	Retain in agency	Retain in line with NPAAC guidelines
4.5.6	**Molecular genetics**			
4.5.6.1		Nucleic acid extracts or frozen plasma for NIPT.	Destroy	Retain 1 year after date of examination, then Destroy.
4.5.6.2		Nucleic acid extracts for somatic or constitutive testing.	Destroy	Retain 3 months from date of issue of the report for an individual or from completion of a family study the proband's sample is

No	Function/Activity	Description	Disposal Action	Custody
Pathology, laboratory record				
				required as a control or from completion of testing, whichever of the three periods is the longest.
4.5.7	**Bioinformatic genetic data**			
4.5.7.1		Read data (e.g. FASTQ) or aligned reads (e.g. BAM).	Destroy	Retain 4 years after date of report issued, then Destroy.
4.5.7.2		Variant call files.	Destroy	Retain 10 years after date of examination, then Destroy.
4.5.7.3		Microarray analysis files.	Destroy	Retain 4 years after date of examination, then Destroy.
4.6	**Haematology**			
4.6.1	**Blood films**			
4.6.1.1		Clinically significant.	Destroy	Retain 1 year after date of examination, then Destroy.
4.6.1.2		Not clinically significant.	Destroy	Retain 1 month after date of examination, then Destroy.

No	Function/Activity	Description	Disposal Action	Custody
Pathology, laboratory record				
4.6.2	**Homeostasis testing**	Plasma for special homeostasis testing.	Destroy	Retain 1 month after date of examination at -20 degrees celsius or lower, then Destroy.
4.6.3	**Blood specimens**	Blood specimens other than those in homeostasis testing.	Destroy	Retain 7 days from date of receipt or until 2 days after final report is issued for purpose of identification and traceability, noting that repeat testing may not be technically reliable after 2 days, then Destroy.
4.6.4	**Bone marrow**	Bone marrow, slides and reports.	Destroy	Retain for 10 years after date of examination or 7 years provided the patient has attained the age of 25 (whichever is the greater), then Destroy.
4.6.5	**Flow Cytometry**			
4.6.5.1		Graphical outputs used in diagnosis such as gated dot plots and histograms.	Destroy	Retain 4 years after date of examination, then Destroy.

No	Function/Activity	Description	Disposal Action	Custody
Pathology, laboratory record				
4.6.5.2		Reports.	Destroy	Retain 10 years after date of examination or 7 years provided the patient has attained the age of 25 (whichever is the greater), then Destroy.
4.7	**Immunohaematology (Blood transfusion)**			
4.7.1	**Laboratory records**	• All laboratory records of immunohaematology testing. • Laboratory records of blood products received and issued.	Destroy	Retain 20 years after date of examination, receipt or issue, then Destroy.
4.8	**Immunology**			
4.8.1	**Frozen tissue blocks**	Frozen tissue blocks including specimens for immunofluorescence.	Destroy	Retain 10 months after date of examination at -70 degrees celsius or lower, then Destroy.
4.8.2	**Immunofluorescence slides**	Immunofluorescence slides.	Destroy	Retain 7 days from date of receipt or until 2 days after the final report is issued (whichever date is later), then Destroy.

No	Function/Activity	Description	Disposal Action	Custody
Pathology, laboratory record				
4.9	**Microbiology**			
4.9.1	**Slides**			
4.9.1.1		Wet preparations.	Destroy	Destroy after examination
4.9.1.2		Immunofluorescence slides.	Destroy	Retain 7 days after date of examination, then Destroy.
4.9.1.3		Ziehl-Neelson stains.	Destroy	Retain 6 weeks after date of examination, then Destroy.
4.9.1.4		Gram and other stained slides.	Destroy	Retain 2 weeks after date of examination, then Destroy.
4.9.2	**Isolates**			
4.9.2.1		Isolates unless addressed by the Security Sensitive Biological Agent legislation. • Clinically significant (i.e. all blood culture and sterile site isolates plus any cultured isolate reported by the laboratory as a potential pathogen).	Destroy	Retain 5 days after date of examination, then Destroy.
4.9.2.2		Isolates unless addressed by the Security Sensitive Biological Agent legislation.	Destroy	Destroy after examination

No	Function/Activity	Description	Disposal Action	Custody
Pathology, laboratory record				
		• Not clinically significant.		
4.9.3	**Infectious disease serology**			
4.9.3.1		Serum/plasma for infectious serology • All sera unless specified in 4.9.3.2	Destroy	Retain 4 months after date of examination, then Destroy.
4.9.3.2		Serum/plasma for infectious serology listed below: • Antenatal sera • Reactive syphilis sera • Source and recipient sera from body fluid exposure (needlestick) where this has been notified to the laboratory.	Destroy	Retain 12 months after date of examination, then Destroy.
4.9.4	**Urine**	Urine specimen for microbiological examination.	Destroy	Retain 3 days from date of issue of report, under refrigeration, then Destroy.
4.9.5	**Nucleic acid**			
4.9.5.1		Nucleic acid for diagnostic microbiological examination - extract or original specimen.	Destroy	Retain 1 month from date of issue of report, then Destroy.
4.9.5.2		Nucleic acid for screening - extract or original	Destroy	Retain 1 month after date of issue of report,

No	Function/Activity	Description	Disposal Action	Custody
Pathology, laboratory record				
		specimen.		then Destroy.
4.10	**Blood alcohol records**			
4.10.1		• Documents concerning taking of blood samples. • Results (positive or negative)	Destroy	Retain 3 years after date of taking blood, then Destroy.
4.10.2		Register of blood samples (electronic or manual) - contains the serial number of the container of blood sample, date and time blood sample was taken and name of the person from whom the sample was taken (or where the name of person is not known, sufficient information to enable the sample to be identified with the person).	Destroy	Retain 7 years after date of taking blood, then Destroy.
4.10.3		Declarations - by a legally qualified medical practitioner as to the grounds for not taking a sample of blood.	Destroy	Retain 7 years after date of declaration, then Destroy.
4.11	**Admission blood samples - Coronial investigations**			
4.11.1		Samples taken on admission to hospitals that may be required for coronial investigation.	Destroy	Retain 14 days after date of admission, then Destroy
5	**Imaging records**	Includes diagnostic images and reports, request forms and paper imaging for diagnostic radiology, nuclear medicine, ultrasound, computed tomography, magnetic resonance imaging and clinical photography		

No	Function/Activity	Description	Disposal Action	Custody
Imaging records				
		records. Note: excludes Aboriginal patient records as per Introduction 1.1.2		
5.1	**Digital imaging**	Includes diagnostic reports, images, request and consent forms held digitally.	Retain in agency	Retain for life of agency
5.2	**Paper records**	Includes photographs etc. Paper imaging to be kept within patient medical record	Destroy	Retain in accordance with 1.1, 1.2, 1.3, 1.4, then destroy
5.3	**Request forms**	Includes original paper requests	Destroy	Retain 7 years after date of report provided the patient has attained the age of 25 years, then Destroy.
6	**Drug records**	Drug or medication charts comprising the medication order(s) written by authorised prescribers and record of administration should be filed in the individual patient record and sentenced according to Index No. 1.1, 1.2, 1.3, 1.4. The retention of the following records for Schedule 8 and Schedule 4 drugs is required under the *Medicines and Poisons Act 2014* and *Regulations 2016*. Note: excludes Aboriginal patient records as per Introduction 1.1.2		
6.1	**Drug of addiction**			

No	Function/Activity	Description	Disposal Action	Custody
Drug records - Drug of addic				
	records (Schedule 8 drugs)			
6.1.1		All records relating to transactions on or after 30 January 2017 involving drugs of addiction including drugs of addiction registers	Destroy	Retain 5 years after last date on record, then Destroy.
6.1.2		All records relating to transactions prior to 30 January 2017 involving drugs of addiction including drugs of addiction registers	Destroy	Retain 7 years after last date on record, then Destroy.
6.2	**Prescriptions only medicines (Schedule 4 drugs)**	All records relating to transactions involving Prescriptions only medicines.	Destroy	Retain 2 years after last date on record, then Destroy.
7	**Community health records**	Records relating to clients of community health centres, child health centres and schools. Note: excludes Aboriginal patient records as per Introduction 1.1.2		
7.1	**Child health records**			
7.1.1		The following Child Health paper records are as follows: • Notification of case attended (MR15) - an electronic version of this form is now widely used. All notifications are electronic. • Child Health Birth Register (CHS 35) - this record is not routinely used by all child health	Destroy	Retain 60 years after date of last documentation, then Destroy.

No	Function/Activity	Description	Disposal Action	Custody
Community health records - C				
		clinics since the introduction of electronic records and is on the CAHS discontinued forms list. • Child Health Record (CHS 560) - this record is not used by all child health clinics since the introduction of electronic records. • Temporary Child Health Record for transfers and visitors (CHS 560A) - formerly known as Temporary Record for Transfers and Visitors (CHS 560A). This record is not used in CAHS-CH since the introduction of electronic records. • Family Health Record (CHS 560B) - this record is not used in CAHS-CH since the introduction of electronic records and is on the CAHS discontinued forms list. • Maternal Health Program (CHS 18) - This card system is no longer used. This class of record remains in the Schedule as the minimum retention requirements may not have expired. • Progress Notes (CHS 017) - This item has been replaced by the CHS 800C. The CHS 800C is used in secondary schools where electronic records are not available and maintained in the CHS 410. These notes can be attached as an addendum to CHS 560 or CHS 560B if additional space for progress notes is needed.		

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No	Function/Activity	Description	Disposal Action	Custody
Community health records - C				
		• Referral form 6-8 weeks Motor Development (CHS 575) - this record is not routinely used by all child health clinics since the introduction of electronic records and is on the CAHS discontinued forms list. Retain duplicate copy with the Child Health Record (CHS 560). • Client details/Genogram CHS 800A-2 - this record is completed by WACHS CHN and scanned into CHIS. Copy is retained. This record is used in CAHS-CH and held in the MR 600. • BTSE Contact Assessment Form (CHS 800B-1) - this record is not routinely used by all child health clinic since the introduction of electronic records. • Family Assessment and Acuity Level (CHS 800B-2) - this record is not routinely used by all child health clinics since the introduction of electronic records. • Community Health Progress Notes (CHS800C) - this record is not routinely used by all child health clinic since the introduction of electronic records. This form is used in secondary schools where electronic records are not available and maintained in the CHS 410.		

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No	Function/Activity	Description	Disposal Action	Custody
Community health records - C				
7.1.2		Child Health Records within in the following systems: • Child Development Information System (CDIS) - used in CAHS • Child Health Information System (CHIS) - used in WACHS These are separate systems that do not interface.	Retain in agency	Retain for life of agency
7.2	**Enhanced Aboriginal child health schedule records**	The below records have been discontinued: • Child history (CHS 703) • Strengths and risk assessment (HS 704) • 0-5 years summary sheet (CHS 718) • Community health assessment checklists (CHS 701, 702, 705-1, 706, 707, 708, 709-1, 710, 711-1, 712, 713-1, 714, 715-1, 716) • Medical Officer Examination Forms (CHS 705-2, 709-2, 711-2, 713-2, 715-2, 717).	Destroy	Retain 60 years after date of last documentation, then Destroy.
7.3	**School health records**			
7.3.1		For the following Primary school health records: • Accident/injury illness record (CHS 50) - this form is no longer in use	Destroy	Retain 60 years after date of last documentation, then Destroy.

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No	Function/Activity	Description	Disposal Action	Custody
Community health records - S				
		• Referral to Community Health Nurse (CHS142) - this form to be stored with CHS 409-1. To be stored in an accessible and secure location until child has completed Year 6. • Class list (CHS143) - to be stored securely and accessible until the children have completed Year 6. • Primary School Health Records (CHS 409) - this consists of the following four parts: Parent consent and child health history (CHS 409-1) - to be stored securely and accessible until the children have completed Year 6. To be stored in an individual folder/file if additional paper records are required e.g. for complex clients. • Results for Staff (CHS 409-2) - to be stored and handles securely until results are entered into CHIS. May be destroyed after activity is completed, including rechecks and referral confirmation, and entered into CHIS. • School Entry Health Consultation for Education Support Students (CHS 409) - to be stored in an accessible and secure location until child has completed Year 6. To be stored in an individual folder/file if additional paper records are required e.g. for complex clients. • Results for Parents (Triplicate) (CHS 409-6A) -		

No	Function/Activity	Description	Disposal Action	Custody
Community health records - S				
		white copy to be provided to parents in envelope, Pink copy to be provided to school. Yellow copy to be stored with CHS 409-1. To be stored securely and accessible until the children have completed Year 6. •		
7.3.2		For the following High school health records are to be to be stored in an accessible and secure location until child has completed year 12: • High School Health Record (CHS 410) • Education Support School/Centre Record (CHS 413) - this form is no longer in use. • School Health Progress Notes (CHS 412) - this form is used as an addendum to Primary School Health Record (CHS 409) and High School Health Record (CHS 410). CHS 800 is used in secondary schools where electronic records are not available. • Year 6 Vision Screening Form (CHS 416) - this form is no longer in use. • Information to Ophthalmologist from Community Health (CHS 418) - this is no longer in use. • Weight Assessment Record (CHS 419) - for	Destroy	Retain 60 years after date of last documentation, then Destroy.

No	Function/Activity	Description	Disposal Action	Custody
Community health records - S				
		Girls (CHS 430A) for boys (CHS 430B). • Psychological Risk Assessment (HEADSS) - Part A used for initial assessment. Part B used for follow-up assessments. • Body Diagram (CHS 422). • Ear Health Assessment Results (CHS 423) - used for ear health assessment as part of a targeted Aboriginal Health program. • Consent for Ear Health School Screening (CHS 719).		
7.3.3		The following High school electronic health record is to be to be stored in an accessible and secure location until child has completed year 12: • School Health Record Transfer (CHS 417)	Retain in agency	Retain for life of agency
7.3.4		The following High school paper health record is to be to be stored in an accessible and secure location until child has completed year 12: • School Health Record Transfer (CHS 417)	Destroy	Retain 60 years after date of last documentation, then Destroy.
7.4	**Other community health records**			
7.4.1		For the following Community health records: • Centralised Client Health Record - where the	Destroy	Retain 60 years after date of last documentation, then

No	Function/Activity	Description	Disposal Action	Custody
Community health records - O				
		centre has an integrated client record to which all practitioners contribute. • Children in Care (CHS 450) - comprehensive health assessment 0-18 years. • Referral from Community Health (CHS 663) - formally known as Confidential Referral Form. • Children's Day Care Form (CHS 414) - this form is no longer in use (discontinued from 1994). This class of record remains in the Schedule as records associated with legal implications may have been retained. • Discipline Specific Client Records - where a record is not compiled in an integrated record and practitioners retain discipline specific records.		Destroy.
7.4.2		For the following Community health record: • Diary (Work) - work diary containing information which identifies an individual client, including details of client appointments, assessments, telephone conversation	Destroy	Retain 60 years after date of last entry, then Destroy.
7.5	**Health centre and immunisation records**	For the following records: • Confidential Records (CHS 28) - this form is no longer used. Contains sensitive information regarding abuse, family disharmony,	Destroy	Retain 60 years after date of last documentation, then Destroy.

No	Function/Activity	Description	Disposal Action	Custody
Dental records				
		developmental disorders, pregnancy etc • Immunisation Record/Request Cards (CHS 631) - this form is no longer used. • The following HP cards are from CDC and are not Community Health records.Aboriginal Child Vaccination Record (HP 2737) • Non-Aboriginal Child Vaccination Record (HP 1059) • Adult Vaccination Catch-up Record (HP 3234) • Child Vaccination Catch-up Record (HP 3235) •		
8	**Dental records**	Refers to Dental Health Services patient records. Note: excludes Aboriginal patient records as per Introduction 1.1.2		
8.1	**Adult dental examination records**		Destroy	Retain 7 years after last attendance, last official contact between facility and client or date of last documentation provided the client has attained the age of 25 years, then Destroy.

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No	Function/Activity	Description	Disposal Action	Custody
Dental records				
8.2	**Child dental examination records**		Destroy	Retain 7 years after last attendance, last official contact between facility and client or date of last documentation provided the client has attained the of 25 years, then Destroy.
9	**Summarised and ephemeral documentation**	This part covers disposal of ephemeral material of a facilitative nature comprising detailed and frequent observations which are subsequently written in full or summary form in the patient record. The transcribed, summarised or edited record is sentenced according to the appropriate class of record. The destruction of these records is authorised as a normal administrative practice and it is not necessary for details of destruction to be entered into a Record Destruction Register. Note: excludes Aboriginal patient records as per Introduction 1.1.2		
9.1	**Observations**	Includes: daily fluid balance record, frequent observations, intensive care observations, respiratory record. (edited and mounted or summarised records are sentenced according to Index No. 1.1, 1.2, 1.3, 1.4).	Destroy	Retain information till transcribed, summarised or edited, then Destroy.
9.2	**Nursing care plans**	Applies to plans which are constantly revised and	Destroy	Retain after reference

No	Function/Activity	Description	Disposal Action	Custody
Summarised and ephemeral doc				
		here revisions obliterate previous entries.		use ceases, then Destroy.
9.3	**Identification of Patients**	Photos of patients used as identification instead of the patient ID bands at the hospital bed.	Destoy	Retain after reference use ceases, then Destroy
10	**Statutory notification of births and deaths**	Births - Required under the *Births Deaths and Marriages Registration Act 1998* s 12 and 13 Deaths - Required under the *Births Deaths and Marriages Registration Act 1998* s 42 to 47 Note: excludes Aboriginal patient records as per Introduction 1.1.2		
10.1	**Births**	The hospital's copy of the Statutory Notification (Notification of Case Attended MR 15) must be filed in the individual patient record. A copy may also be retained separately.	Destroy	Retain 7 years after the child has attained 18 years, then Destroy.
10.2	**Deaths**	The Death Certificate book contains the death certificate completed by a Doctor, with the original going to the Funeral Director and if applicable, one duplicate going into the patient record.	Destroy	Retain 10 years after last certificate in the booklet is issued, then Destroy.
11	**Statutory health notification forms**	Refers to copies of forms or butts of documents fulfilling obligations under the following legislation: *Public Health Act 2016 s 94* *Public Health Regulations 2017 reg 3 and 4*		

No	Function/Activity	Description	Disposal Action	Custody
Statutory health notificatio				
		Mental Health Act 2014 s204, 222, 240 *Voluntary Assisted Dying Act 2019 s21, s32, s45, s49, s57(3)(a), s63(3)(b), s157(4)(b)* *Health (Notification of Lead Poisoning) Regulations 1985* reg 5 *Health (Western Australian Cancer Register) Regulations 2011 reg 5, 6, 7 and 8* The hospital copy of the form or butt may be filed in the individual patient record or retained in separate agency files. Previous Statutory Health Notification Forms collected under previous legislation are still to be kept in accordance with this section. Note: excludes Aboriginal patient records as per Introduction 1.1.2		
11.1	**Statutory health notification forms**			
11.1.1		Statutory health notification forms filed in the individual patient record	Destroy	Retain in accordance with 1.1, 1.2, 1.3, or 1.4, then Destroy
11.1.2		Statutory health notification forms filed within agency notification files	Destroy	Retain 10 years after date of notification, provided there is no

No	Function/Activity	Description	Disposal Action	Custody
Statutory health notificatio				
				reasonable expectation of legal implication at time of disposal, then Destroy.
11.1.3		A register (electronic or paper) used to list statutory health records. These records are restricted access archives.	Required as State archives	Archive within agency
11.2	**Infectious disease register documents**	Includes: • Infectious Disease Notification forms • HIV Notification form • Acquired immune deficiency syndrome (AIDS) Notification form • Adverse Immunisation Events form.		
11.2.1		For agency notification forms	Destroy	Retain 10 years after date of notification provided there is no reasonable expectation of legal implication at time of disposal for Agency notification files, then Destroy.
11.2.2		Statewide Infectious Disease Notification Database.	Required as State archives	Retain for life of agency

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No	Function/Activity	Description	Disposal Action	Custody
Statutory health notificatio				
		These records are restricted access archives.		
11.2.3		A register (electronic or paper) used to list infectious disease notifications. These records are restricted access archives.	Required as State archives	Retain 25 years after reference use ceases, then transfer to the SRO.