Policy Statement	The Laboratory is committed to providing useful clinical data to providers.
Purpose	To provide the required elements of a patient report and distinguish when results are reported.
Scope	This policy applies to all sections within the Department of Pathology.
Responsibility	The Medical Director, Lead Technologists and LIS Coordinator will ensure that all generated reports have the required elements. It is the responsibility of Leads and the LIS Coordinator to ensure that the required elements are available with the results when transferred to the electronic medical record (EMR) through the various interfaces. The Medical Director will provide input regarding whether external laboratory reports are reported in the electronic medical record. The Medical Director is not responsible for the content of external laboratory reports.

Report Elements

Reports generated by the Laboratory must include the following elements:

- Name and address of the testing laboratory
- Patient name and unique patient identifier
- Name of physician or authorized provider of record
- Date and time of specimen collection, when appropriate
- Specimen source, when applicable
- Test results(s) including units of measurement, when applicable
- Reference intervals, as applicable
- Conditions of specimen that may limit adequacy of testing

All of the above elements are available in the laboratory information system (LIS) or in paper records. For electronic reports, data elements need not all be present on one screen, but must be readily available. Reports must include the name and address of reference laboratories where patient testing was performed. For electronic reports, the name and address of reference laboratories are not required but must be available in the LIS. Paper and electronic report content is reviewed annually by the LIS Coordinator and Medical Director to ensure that the integrity of the report is maintained.

Reporting Results from External Sources

Reports from an external source, not deemed as a Saint Agnes reference lab or critical supplier are not included in the primary laboratory reporting system of the EMR. In the event that a request is received, an external document may be incorporated in the patient's EMR to ensure continuity of care and reduce unnecessary test duplication. Documents will be scanned into the EMR. Scanning will not be completed by the Department of Pathology, nor do they have to be notified of the incorporation of the document.

In the event that the Laboratory utilizes external patient data to evaluate, diagnose, or establish a patient history, the document must be scanned into the EMR. It is preferable that these documents include; laboratory or source name and address, patient name and identification number, date of collection, test result(s), reference range and units, where applicable. Documents will be scanned into the EMR using the Form ID; PATHOUTSIDEMA (Pathology Outside Material) or CDLABOUTSIDERPT (Outside Laboratory Report). Outside reports scanned in during the registration process will be stored under the Other Reports tab of the EMR as Clinical Pathology Requisition.

Related Documents

LADM 2102 R Document Scanning
LADM 7115 Q LIS Integrity
LADM 7115 Fa Integrity Review Checklist

References

CLIA §493.1291