Authority number: PROS 11/06 VAR 2

PROS 11/06 VAR 2

Retention and Disposal Authority for Records of Patient Information

Status Date: 13/05/2026

Retention and Disposal Authority for Records of Patient Information

Authority number: PROS 11/06 VAR 2

Variation 1

Public Records Act 1973 (Section 12)

Retention and Disposal Authority for Patient Information Records

Public Record Office Standard (PROS) 11/06

Variation 1:

In accordance with section 12 of the Public Records Act 1973 (as amended), I hereby vary the Standard applying to Patient Information records, issued as Public Record Office Standard (PROS) 11/06 on 09/09/2011, as follows:

Extension of the application of this Authority until varied or revoked.

The addition of the following text to the scope of the RDA and across the body as a footer:

This Retention and Disposal Authority **must be used in conjunction with PROS 19/08** Retention and Disposal Authority for Records of Organisational Response to Child Sexual Abuse Incidents and Allegations for records of child sexual abuse prevention, identification, investigation and resolution. PROS 19/08 will apply unless existing retention periods in this RDA are greater than or equal to those specified in PROS 19/08.

Class Number	Description of Change
2.0	Cross-reference to child sexual abuse reporting class 4.3.1 and to PROS 19/08
2.1	Cross-reference to class 2.7.1 for records of patients treated where child sexual abuse is reported or disclosed
2.2	Cross-reference to class 2.7.1 for records of patients treated where child sexual abuse is reported or disclosed
2.3	Cross-reference to class 2.7.1 for records of patients treated where child sexual abuse is reported or
2.7	New activity for the treatment and care of patients where child sexual abuse is reported or disclosed

Retention and Disposal Authority for Records of Patient Information

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2.7.1	New class to cover records of patient treatment where child sexual abuse is reported or disclosed with 99 year retention period
4.0	Cross-reference to patient treatment records class 2.7.1 and to PROS 19/08
4.3	Name changed to 'Reporting of Suspected Criminal Activity'
4.3.1	Amendment to the class to cover only records of the reporting to appropriate authorities of child sexual abuse incidents or disclosures, retention period increased to 99 years
4.3.2	New class covering the reporting to appropriate authorities of patients presenting with suspected injuries resulting from child abuse or neglect (previously covered by 4.3.1)
4.3.3	New class covering reports made to appropriate authorities for adult patients presenting with suspected injuries suspected to be caused by criminal activity, including sexual assault or physical assault (previously covered by 4.3.1)

This Variation shall have effect from its date of issue.

[signed]

Justine Heazlewood

Director and Keeper of Public Records

Date: 14 November 2019

Retention and Disposal Authority for Records of Patient Information

Authority number: PROS 11/06 VAR 2

Variation 2

Public Records Act 1973 (Section 12)

Retention and Disposal Authority for Records of Patient Information

Public Record Office Standard (PROS) 11/06

Variation 2:

In accordance with section 12 of the Public Records Act 1973 (as amended), I hereby vary the Standard applying to the records of patient information, issued as Public Record Office Standard (PROS) 11/06 on 9 September 2011, as follows:

- Addition of a new function - Function 8: Patient Transport Service
- Addition of a new activity – Activity 8.1 : Non-emergency transport service provision
- Addition of a new class 8.1.1 for booking forms requesting the transport service.

This Variation shall have effect from its date of issue.

[approved]

Rowan Enright

Acting Director and Keeper of Public Records

Date of issue: 13 May 2026

Authority number: PROS 11/06 VAR 2

Copyright Statement

Disclaimer

The State of Victoria gives no warranty that the information in this version is correct or complete, error free or contains no omissions. The State of Victoria shall not be liable for any loss howsoever caused whether due to negligence or otherwise arising from the use of this Standard.

Authority number: PROS 11/06 VAR 2

Retention and Disposal Authority for Records of Patient Information

Retention and Disposal Authority No	PROS 11/06 VAR 2

Scope	Authorises disposal of patient information records created by health service agencies. PROS 11/06 authorises the disposal of records created during and post 1950 in accordance with its provisions. PROS 11/06 does not authorise the disposal of records created before 1950. Public Record Office Victoria must be contacted for advice on disposal of pre 1950 records. This Retention and Disposal Authority must be used in conjunction with PROS 19/08 Retention and Disposal Authority for Records of Organisational Response to Child Sexual Abuse Incidents and Allegations for records of child sexual abuse prevention, identification, investigation and resolution. PROS 19/08 will apply unless existing retention periods in this RDA are greater than or equal to those specified in PROS 19/08.

Status	Issued by Keeper

Issue Date	13/05/2026

Retention and Disposal Authority for Records of Patient Information

Authority number: PROS 11/06 VAR 2

List of Functions and Activities covered

Retention and Disposal Authority for Records of Patient Information

Authority number: PROS 11/06 VAR 2

List of Functions and Activities covered

Retention and Disposal Authority for Records of Patient Information

Authority number: PROS 11/06 VAR 2

List of Functions and Activities covered

Authority number: PROS 11/06 VAR 2

Introduction

Purpose of this Authority

The purpose of this Authority is to provide a mechanism for the disposal of public records in accordance with the *Public Records Act 1973.* The Authority:

- identifies records which are worth preserving permanently as part of Victoria's archival heritage
- prevents the premature destruction of records which need to be retained for a specified period to satisfy legal, financial and other requirements of public administration, and
- authorises the destruction of those records not required permanently.

Context of this Authority

Public Record Office Victoria Standards

This Authority should be used in conjunction with the Standards issued by the Keeper of Public Records under Section 12 of the *Public Records Act 1973.* Copies of all relevant PROV standards, specifications and regulatory advice can be downloaded from www.prov.vic.gov.au. These documents set out the procedures that must be followed by Victorian public offices.

Disposal of records identified in the Authority

Disposal of public records identified in this Authority must be undertaken in accordance with the requirements of Public Record Office Standard - *Disposal.*

It is a criminal offence to unlawfully destroy a public record under s 19(1) of the *Public Records Act 1973.*

The destruction of a public record is not unlawful if done in accordance with a Standard established under s 12 of the *Public Records Act 1973.*

This Standard (also known as an Authority) authorises the disposal of public records as described within its provisions. However, disposal is **not** authorised under this Standard if it is reasonably likely that the public record will be required in evidence in a current or future legal proceeding.

Retention and Disposal Authority for Records of Patient Information

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For the purposes of this Retention and Disposal Authority, a 'legal proceeding' has the same meaning as the *Evidence (Miscellaneous Provisions) Act 1958*, and includes any civil, criminal or mixed proceeding and any inquiry in which evidence is or may be given before any court or person acting judicially, including a Royal Commission or Board of Inquiry under the *Inquiries Act 2014.*

Under PROS 22/04 Disposal Standard, authorisation to destroy public records is WITHDRAWN and NOT GIVEN (even if specified in an RDA or other authorised disposal instrument) if:

- it is reasonably likely that they will be needed in a current or future legal proceeding. This includes any civil or criminal proceeding or an inquiry where evidence may be given before a court or person acting judicially such as a Royal Commission or Board of Inquiry
- they are required for meeting any Freedom of Information (FOI) applications which are not finalised
- they are required for audits or investigations which are not yet finalised; and/or
- they are subject to disposal freezes applied by government or by the organisation.

If the public office identifies that public records must be retained under other applicable legislation for a period that exceeds the retention period specified under the Standards, then the longer retention period must apply.

Access by or on behalf of a patient

'Access by or on behalf of the patient' refers to access for the purposes of providing patient treatment and care. It does not refer to access for legal or other purposes which do not relate directly to a patient's treatment or care. For further advice regarding the disposal of records subject to or likely to be subject to legal proceedings refer to 'Disposal of records identified in the Authority' in the Introduction section of this RDA.

Normal Administrative Practice

PROS 22/04 Disposal Standard authorises the destruction of some public records under Normal Administrative Practice (NAP) principles. Low value facilitative records described below are authorised for destruction by *PROS 22/04* under NAP principles:

- working documents, such as notes or calculations, used to assist in the preparation of other records
- minor drafts and transitory documents, where the content is reproduced elsewhere, and the information will not be needed to show how the work has progressed or actions approved
- minor updates of content, such as those in databases, which will not be needed to show actions, decisions, or approvals

Authority number: PROS 11/06 VAR 2

- communications for the purpose of making minor arrangements
- duplicate copies
- periodic backups of records, information, data, software and settings for recovery in case of technical failure and/or catastrophe and are duplicate copies of official business records/data that is held elsewhere on a managed system.

Retention and Disposal Authority for Records of Patient Information

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Transfer of records to Public Record Office Victoria
Contact Public Record Office Victoria for further information on procedures for transferring permanent records to archival custody.

Use of Other Authorities

In applying the disposal sentences set out in this Authority, reference should be made to other current Authorities where applicable. Where there is a conflict between two Authorities (for instance this Authority and the General Retention and Disposal Authority for Records of Common Administrative Functions), consult the Public Record Office Victoria for advice.

Explanation of Authority Headings

Class Number
The class number or entry reference number provides citation and ease of reference.

Description
The description of each record class is specified in this entry. A record class is a group of records that relate to the same activity, function or subject and require the same disposal action.

Status
This entry provides the archival status of each class - either permanent or temporary.

Custody
This entry specifies whether the records are to be retained by the public office or transferred to the Public Record Office Victoria. Permanent records must be managed and transferred in accordance with PROV Standards.

Retention and Disposal Authority for Records of Patient Information

Authority number: PROS 11/06 VAR 2

Concurrence of Public Office

This Authority has the concurrence of:

_____

Signed: [signed]

Name: Fran Thorn

Position: Secretary, Department of Health

Date: 02/09/2011

_____

Establishment of Standard

Pursuant to Section 12 of the Public Records Act 1973, I hereby establish these provisions as a Standard (also known as a Retention and Disposal Authority) applying to Health Agencies, all. This standard as varied or amended from time to time, shall have effect from the date of issue unless revoked.

[signed]

Justine Heazlewood, Keeper of Public Records

Date of Issue: 09/09/2011

Retention and Disposal Authority for Records of Patient Information

Authority number: PROS 11/06 VAR 2

No	Function/Activity	Description	Status	Disposal Action
1	**PATIENT ASSESSMENT, REGISTRATION AND ADMISSSION**	The assessment of persons for treatment by a health service, the registration of patients, and admission into a health service for inpatient or outpatient treatment.		
1.1	**Patient Assessment**	The assessment of prospective patients for treatment and/or admission. Includes the assessment of injured or ill people presenting at emergency or casualty desks without referral for treatment.		
1.1.1		Records of assessment that results in treatment or care. Includes referrals and records of triage activities. [For appointment records, use 1.1.4]	Temporary	Destroy 15 years after date of last attendance, or access by or on behalf of the patient provided they have reached 30 years of age.
1.1.2		Records of assessment that **does not** result in treatment or care, Includes referrals and records of triage activities.	Temporary	Destroy 12 years after last action.
1.1.3		Referrals which do not result in an assessment, treatment nor care. [For appointment records, use 1.1.4]	Temporary	Destroy 2 years after last action.
1.1.4		Appointment records.	Temporary	Destroy 2 years after last action.

This Retention and Disposal Authority **must be used in conjunction with PROS 19/08** Retention and Disposal Authority for Records of Organisational Response to Child Sexual Abuse Incidents and Allegations for records of child sexual abuse prevention, identification, investigation and resolution.

Authority number: PROS 11/06 VAR 2

No	Function/Activity	Description	Status	Disposal Action
PATIENT ASSESSMENT, REGISTRATION AND ADMISSSION - Patient Registration				
1.2	**Patient Registration**	The activity of uniquely identifying patients, including the allocation of a unique identifier for each patient to ensure matching of individual patients to medical and financial records and to trace patient movement. [Excludes the state-wide registration of mental health patients. See *Retention and Disposal Authority for Records of Mental Health, Alcohol and Drugs Service Functions* PROS 09/09]		
1.2.1		Records which uniquely identify each patient, including the allocation of a unique identifier (eg Unit Record (UR) number) for each patient. Includes name, address and date of birth. May include health insurance details, next of kin, guardian (if applicable), referring practitioner, concession eligibility, and summary note of the authority for admission and treatment (if applicable). [Excludes consents or any legal instruments authorising admission, use 1.3.1]	Temporary	Destroy 75 years after last action.
1.3	**Patient Admission**	The admission of patients to a hospital or health facility, including the allocation of accommodation and services.		

Authority number: PROS 11/06 VAR 2

No	Function/Activity	Description	Status	Disposal Action
PATIENT ASSESSMENT, REGISTRATION AND ADMISSSION - Patient Admission				
1.3.1		Records documenting the admission of individual patients and the authority under which they were admitted. Includes formal orders, warrants and consents authorising admission. Includes the initial allocation of accommodation and services to patients and assigning a primary medical practitioner responsible for the patient. [Excludes orders and warrants under the *Mental Health Act,* see 1.3.2]	Temporary	Destroy 15 years after date of last attendance, or access by or on behalf of the patient provided they have reached 30 years of age.
1.3.2		Records authorising the admission and movement of patients under the *Mental Health Act*. Includes authorisation to transport and transfer orders. Includes formal orders and warrants. [For records of patient treatment during transfer, see 2.0.0 Patient Treatment and Care.]	Temporary	Destroy 25 years after date of last attendance, or access by or on behalf of the patient provided they have reached 43 years of age.
1.3.3		Records of patients' Medicare details, health insurance or other payment arrangements for treatment.	Temporary	Destroy 7 years after last action.
1.3.4		Submission of Acute Care Certificates as per the Private Health Insurance (Benefit Requirements) for patients who would ordinarily be residing in aged care accommodation, but require admission for	Temporary	Destroy 7 years after last action.

This Retention and Disposal Authority **must be used in conjunction with PROS 19/08** Retention and Disposal Authority for Records of Organisational Response to Child Sexual Abuse Incidents and Allegations for records of child sexual abuse prevention, identification, investigation and resolution.

Authority number: PROS 11/06 VAR 2

No	Function/Activity	Description	Status	Disposal Action
PATIENT TREATMENT AND CARE				
		treatment of a condition that would usually be provided under out-patient conditions e.g. chemotherapy, radiation therapy.		
2	**PATIENT TREATMENT AND CARE**	Provision of medical examination, diagnosis, treatment, care services and advice to acute, sub-acute and mental health patients. Refers to admitted, non-admitted and emergency department patients. Includes treatment and services from allied health professionals which includes but is not limited to: • Occupational therapy • Speech therapy • Pathology • Pharmacology • Podiatry • Social work • Physiotherapy • Psychology		

This Retention and Disposal Authority **must be used in conjunction with PROS 19/08** Retention and Disposal Authority for Records of Organisational Response to Child Sexual Abuse Incidents and Allegations for records of child sexual abuse prevention, identification, investigation and resolution.

Authority number: PROS 11/06 VAR 2

No	Function/Activity	Description	Status	Disposal Action
PATIENT TREATMENT AND CARE - Emergency Department Patient Treatment and Care				
		Includes records of patients treated where child abuse is reported or disclosed. [For records of reporting of child sexual abuse incidents or disclosures, including mandatory reporting, see 4.3.1] [For records of the agency's prevention, identification and response to child sexual abuse incidents and allegations, use PROS 19/08 RDA for Records of Organisational Response to Child Sexual Abuse Incidents and Allegations.] [For the treatment of pre 1996 mental health patients (voluntary and involuntary) provided by State institutions, use PROS 09/09 RDA for *Records of Mental Health, Alcohol and Drugs Services*.]		
2.1	**Emergency Department Patient Treatment and Care**	The treatment and care of patients by an emergency department of a public hospital or health facility who are discharged from the emergency department and are not admitted for further treatment and care as either an inpatient or outpatient. [For assessments that do not result in treatment, use 1.1.2.]		

This Retention and Disposal Authority **must be used in conjunction with PROS 19/08** Retention and Disposal Authority for Records of Organisational Response to Child Sexual Abuse Incidents and Allegations for records of child sexual abuse prevention, identification, investigation and resolution.

Authority number: PROS 11/06 VAR 2

No	Function/Activity	Description	Status	Disposal Action
PATIENT TREATMENT AND CARE - Emergency Department Patient Treatment and Care				
		[For emergency department patients subsequently admitted as an inpatient, use 2.2.0.] [For emergency department patients subsequently treated as an outpatient, use 2.3.0.] [For records of patients treated where child sexual abuse is reported or disclosed use 2.7.1.]		
2.1.1		Records of emergency department patients, who are not admitted for further treatment and care as either an inpatient or outpatient, where treatment in emergency department **included** blood transfusion or the receipt of blood product.	Temporary	Destroy 20 years after date of last attendance, or access by or on behalf of the patient provided they have reached 30 years of age.
2.1.2		Records of emergency department patients who are not admitted for further treatment and care as either an inpatient or outpatient, where treatment **did not include** blood transfusion or the receipt of blood product.	Temporary	Destroy 12 years after date of last attendance, or access by or on behalf of the patient provided they have reached 30 years of age.

This Retention and Disposal Authority **must be used in conjunction with PROS 19/08** Retention and Disposal Authority for Records of Organisational Response to Child Sexual Abuse Incidents and Allegations for records of child sexual abuse prevention, identification, investigation and resolution.

Authority number: PROS 11/06 VAR 2

No	Function/Activity	Description	Status	Disposal Action
PATIENT TREATMENT AND CARE - Emergency Department Patient Treatment and Care				
2.1.3		Records of emergency department patients who die while or after receiving treatment in an emergency department.	Temporary	Destroy 12 years after date of last attendance, or access on behalf of the patient.
2.2	**Admitted Patient Treatment and Care**	The treatment and care of admitted patients. Admitted patients are defined as those patients who meet the criteria contained in the Victorian Hospital Admissions Policy. Includes patients admitted for overnight stays and day patients. [For records of patients treated where child sexual abuse is reported or disclosed use 2.7.1.]		
2.2.1		Records documenting admitted patient treatment and care under *Mental Health Act* [gazetted mental health service].	Temporary	Destroy 25 years after date of last attendance, or access by or on behalf of the patient provided they have reached 43 years of age.
2.2.2		Records documenting admitted patient treatment and care where treatment **included** a blood transfusion or treatment with blood products. [Excludes patient treatment under *Mental Health Act,* use 2.2.1]	Temporary	Destroy 20 years after date of last attendance, or access by or on behalf of the patient provided they have

This Retention and Disposal Authority **must be used in conjunction with PROS 19/08** Retention and Disposal Authority for Records of Organisational Response to Child Sexual Abuse Incidents and Allegations for records of child sexual abuse prevention, identification, investigation and resolution.

Authority number: PROS 11/06 VAR 2

No	Function/Activity	Description	Status	Disposal Action
PATIENT TREATMENT AND CARE - Admitted Patient Treatment and Care				
				reached 30 years of age.
2.2.3		Records documenting admitted patient treatment and care where treatment **did not include** blood transfusions or treatment with blood products. [Excludes patient treatment under *Mental Health Act,* use 2.2.1]	Temporary	Destroy 15 years after date of last attendance, or access by or on behalf of the patient provided they have reached 30 years of age.
2.2.4		Records documenting admitted patient treatment and care of those patients who die. Includes deaths whilst receiving treatment and those that occur after discharge. [Excludes obstetric patients, use 2.2.5]	Temporary	Destroy 12 years after the date of death of the patient or last access on behalf of the patient.
2.2.5		Records documenting treatment and care of an obstetric patient and child. [Excludes patient treatment under *Mental Health Act*, use 2.2.1]	Temporary	Destroy 15 years after date of last attendance or access by or on behalf of the patient provided the child has reached 30 years of age.
2.2.6		Records documenting patient treatment and care where patients have been admitted to hospital for	Temporary	Destroy 50 years after date of last attendance,

Authority number: PROS 11/06 VAR 2

No	Function/Activity	Description	Status	Disposal Action
PATIENT TREATMENT AND CARE - Non-Admitted Patient Treatment and Care				
		counselling and/or treatment for gender identity disorder.		or access by or on behalf of the patient.
2.3	**Non-Admitted Patient Treatment and Care**	Refers to the treatment and care of non-admitted outpatients and sub-acute ambulatory care service patients. Non-admitted patients are those for whom the hospital/service does not assume primary responsibility for the treatment and care of the patient's medical condition/s, but instead delivers treatment and care upon referral by the patient's primary medical practitioner. [For records of treatment and care of outpatients and sub-acute ambulatory care service patients who were previously or subsequently admitted during the course of treatment for their medical condition, use 2.2.0 Admitted Patients.] [For records of patients treated where child sexual abuse is reported or disclosed use 2.7.1.]		
2.3.1		Records documenting treatment and care under the *Mental Health Act* [gazetted mental health services] for non-admitted outpatient, ambulatory, and community based patients.	Temporary	Destroy 25 years after date of last attendance, or access by or on behalf of the patient provided they have

This Retention and Disposal Authority **must be used in conjunction with PROS 19/08** Retention and Disposal Authority for Records of Organisational Response to Child Sexual Abuse Incidents and Allegations for records of child sexual abuse prevention, identification, investigation and resolution.

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No	Function/Activity	Description	Status	Disposal Action
PATIENT TREATMENT AND CARE - Non-Admitted Patient Treatment and Care				
				reached 43 years of age.
2.3.2		Records documenting treatment and care of non-admitted patients of out-patient and sub-acute ambulatory care services where treatment **included** a blood transfusion or treatment with blood products.	Temporary	Destroy 20 years after date of last attendance, or access by or on behalf of the patient provided they have reached 30 years of age.
2.3.3		Records documenting treatment and care of non-admitted patients of out-patient and sub-acute ambulatory care services where treatment **did not include** a blood transfusion or treatment with blood products.	Temporary	Destroy 12 years after date of last attendance, or access by or on behalf of the patient provided they have reached 30 years of age.
2.3.4		Records documenting treatment and care of those non-admitted patients who die. Includes deaths whilst receiving treatment and those that occur after treatment ceases.	Temporary	Destroy 12 years after the date of death of the patient or last access on behalf of the patient.
2.3.5		Records documenting treatment and care of non-admitted patients receiving dental services. Includes impressions and casts of patient dental structure.	Temporary	Destroy 12 years after date of last attendance, or access by or on behalf of the patient

This Retention and Disposal Authority **must be used in conjunction with PROS 19/08** Retention and Disposal Authority for Records of Organisational Response to Child Sexual Abuse Incidents and Allegations for records of child sexual abuse prevention, identification, investigation and resolution.

Authority number: PROS 11/06 VAR 2

No	Function/Activity	Description	Status	Disposal Action
PATIENT TREATMENT AND CARE - Assisted Reproductive Technology (ART)				
		[For patients who are admitted for treatment as an inpatient, use 2.2.0 Admitted Patients.]		provided they have reached 30 years of age.
2.4	**Assisted Reproductive Technology (ART)**	The treatment and care of patients of Assisted Reproductive Technology (ART) procedures including In Vitro Fertilisation (IVF), gamete intrafallopian transfer (GIFT) and artificial insemination. Includes case management of each individual person or family unit, consent to ART procedures, donation and use of gametes (semen or ova) or embryos, and the withdrawal of consent for such procedures/use.		
2.4.1		Records of Assisted Reproductive Technology patients where a child is born or pregnancy achieved using donated gametes or embryos.	Permanent	Retain as State archives
2.4.2		Records of Assisted Reproductive Technology patients where a child is born from non-donated gametes or embryos.	Temporary	Destroy 75 years after date of last attendance, or access by or on behalf of the patient.
2.4.3		Records of Assisted Reproductive Technology patients where a child is not born.	Temporary	Destroy 15 years after date of last attendance, or access by or on behalf of the patient.

Authority number: PROS 11/06 VAR 2

No	Function/Activity	Description	Status	Disposal Action
PATIENT TREATMENT AND CARE - Assisted Reproductive Technology (ART)				
2.4.4		Records of donors of gametes or embryos for reproductive procedures.	Permanent	Retain as State archives
2.5	**Treatment Consents and Authorisation**	The provision of consent or authorisations for patient treatment and care including participation in research and clinical trials.		
2.5.1		Records of consent by patients or their authorised representative for treatment, refusal of treatment (do not resuscitate), and organ donations. Includes consents to participate in clinical trials and research. [Excludes gazetted mental health services, use 2.5.2]	Temporary	Destroy after Temporary Dispose in accordance with Patient Treatment and Care, 2.1.0 – 2.4.0.
2.5.2		Records authorising or consenting to patient treatment (warrants and orders) for gazetted mental health services including: • the use of seclusion, electroconvulsive therapy, pharmacological therapy, and mechanical restraints • involuntary treatment • compulsory treatment • the attendance and examination of persons.	Temporary	Destroy 25 years after date of last attendance, or access by or on behalf of the patient provided they have reached 43 years of age.

This Retention and Disposal Authority **must be used in conjunction with PROS 19/08** Retention and Disposal Authority for Records of Organisational Response to Child Sexual Abuse Incidents and Allegations for records of child sexual abuse prevention, identification, investigation and resolution.

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No	Function/Activity	Description	Status	Disposal Action
PATIENT TREATMENT AND CARE - Treatment Consents and Authorisation				
2.5.3		Applications to the Psychosurgery Review Board to perform psychosurgery. Includes determinations (successful and unsuccessful).	Temporary	Destroy 15 years after date of last attendance, or access by or on behalf of the patient provided they have reached 30 years of age.
2.5.4		Reporting of recovery and response to psychosurgery performed under approval of the Psychosurgery Review Board.	Temporary	Destroy 15 years after date of last attendance, or access by or on behalf of the patient provided they have reached 30 years of age.
2.6	**Secondary Consultations**	The provision of specialist medical advice, in the form of a secondary consultation, requested by a medical practitioner or health service on the treatment of a patient. Includes, for example, secondary consultations provided by specialist eating disorder units or drug and alcohol rehabilitation units. For advice received from secondary consults dispose in accordance with the patient record.		
2.6.1		Records documenting advice provided to another medical practitioner or health service in the form of a	Temporary	Destroy 7 years after advice provided.

This Retention and Disposal Authority **must be used in conjunction with PROS 19/08** Retention and Disposal Authority for Records of Organisational Response to Child Sexual Abuse Incidents and Allegations for records of child sexual abuse prevention, identification, investigation and resolution.

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No	Function/Activity	Description	Status	Disposal Action
PATIENT TREATMENT AND CARE - Child Sexual Abuse Incidents and Disclosures				
		secondary consultation. Records include the patient's conditions upon which advice was developed, and summary of advice provided.		
2.7	**Child Sexual Abuse Incidents and Disclosures**	The treatment and care of patients where child sexual abuse is reported or disclosed. Includes the care of children who present with suspected cases of sexual abuse. Includes all patients including admitted, non-admitted and emergency department patients.		
2.7.1		Records of patients treated where child sexual abuse is reported or disclosed. Includes the care of children who present with suspected cases of sexual abuse. Includes all patients including admitted, non-admitted and emergency department patients. [For records of reporting of child sexual abuse incidents or disclosures, including mandatory reporting, see 4.3.1]	Temporary	Destroy 99 years after action completed.
3	**DIAGNOSTIC AND TESTING SERVICES**	The analysing and determining the nature or cause of a patient's poor physical or mental health, through diagnostic and testing services, in order to determine the course of treatment. [For records of diagnostic reports which form part of a patient history, see 2.0.0.]		

This Retention and Disposal Authority **must be used in conjunction with PROS 19/08** Retention and Disposal Authority for Records of Organisational Response to Child Sexual Abuse Incidents and Allegations for records of child sexual abuse prevention, identification, investigation and resolution.

Authority number: PROS 11/06 VAR 2

No	Function/Activity	Description	Status	Disposal Action
DIAGNOSTIC AND TESTING SERVICES - Pathology Diagnostic Services				
		[For records of new born congenital metabolic disorder screening, see *Retention & Disposal Authority for Records of Statewide Health Services*.]		
3.1	**Pathology Diagnostic Services**	The procedures and tests performed by a pathology service on specimens taken from the body of a patient. Includes requests and instructions for carrying out diagnostic examinations. Includes: • Anatomical Pathology (Histopathology) • Cytology • Haematology • Clinical Chemistry/Chemical Pathology • Blood Banks • Immunology • Microbiology • Genetics.		

This Retention and Disposal Authority **must be used in conjunction with PROS 19/08** Retention and Disposal Authority for Records of Organisational Response to Child Sexual Abuse Incidents and Allegations for records of child sexual abuse prevention, identification, investigation and resolution.

Authority number: PROS 11/06 VAR 2

No	Function/Activity	Description	Status	Disposal Action
DIAGNOSTIC AND TESTING SERVICES - Pathology Diagnostic Services				
3.1.1		Requests for pathology procedures.	Temporary	Destroy 1 year after request is fulfilled.
3.1.2		Examined material, diagnostic recordings and laboratory results created in the process of diagnosing a patient.	Temporary	Destroy after in accordance with standards and guidelines issued by the National Pathology Accreditation Advisory Council.
3.1.3		Records documenting the evaluation and interpretation of results of pathological examinations performed for patient diagnosis.	Temporary	Destroy after Temporary Dispose in accordance with 2.0.0 Patient Treatment and Care.
3.2	**Non-Pathological Diagnostic Procedures and Tests**	Refers to non-pathological procedures and tests, including imaging, for the purpose of patient diagnosis. Includes the reporting of results.		
3.2.1		Requests for procedures including X-rays, Computed Tomography (CT) scans, ultrasounds and cardiotocograms.	Temporary	Destroy 1 year after request is fulfilled.
3.2.2		Records documenting results from a diagnostic procedure.	Temporary	Destroy 5 years after creation.

This Retention and Disposal Authority **must be used in conjunction with PROS 19/08** Retention and Disposal Authority for Records of Organisational Response to Child Sexual Abuse Incidents and Allegations for records of child sexual abuse prevention, identification, investigation and resolution.

Authority number: PROS 11/06 VAR 2

No	Function/Activity	Description	Status	Disposal Action
DIAGNOSTIC AND TESTING SERVICES - Non-Pathological Diagnostic Procedures and Tests				
		Examples include: • Radiology (X-Rays) Images • Recordings of electroencephalograms, electrocardiograms, electromyograms, cardiotocograms etc • Ultra-Sound Images • Computed Tomography (CT) scans • Magnetic Resonance Images (MRI) • Photographs • Measurements, gradings, readings and other data. Completed worksheets, questionnaires or surveys.		
3.2.3		Records documenting the evaluation and interpretation of imaging records created for patient diagnosis.	Temporary	Destroy after Temporary Dispose in accordance with 2.0.0 Patient Treatment and Care.

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Authority number: PROS 11/06 VAR 2

No	Function/Activity	Description	Status	Disposal Action
STATUTORY REPORTING AND MONITORING OF PATIENTS				
4	**STATUTORY REPORTING AND MONITORING OF PATIENTS**	The reporting of medical and non-medical conditions as required by legislation. Includes: • reporting to the Registry of Births, Death and Marriages, • the mandatory reporting of treatment under the *Mental Health Act*, • reporting for public health policy and planning purposes and • reporting of injury/illness suspected to be caused by criminal activity. [For treatment authorisations see 2.0.0 Patient Treatment and Care.] [For records of patients treated where child abuse is reported or disclosed use 2.7.1.] [For records of the agency's prevention, identification and response to child sexual abuse incidents and allegations, use PROS 19/08 RDA for Records of Organisational Response to Child Sexual Abuse Incidents and Allegations.]		

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Authority number: PROS 11/06 VAR 2

No	Function/Activity	Description	Status	Disposal Action
STATUTORY REPORTING AND MONITORING OF PATIENTS - Birth and Death Recording and Notification				
4.1	**Birth and Death Recording and Notification**	The recording of births and deaths that have occurred in a public hospital or health service. Includes the notification of births and deaths to the Registry of Births, Deaths and Marriages.		
4.1.1		Notification of births that have occurred in a public hospital or health service to the Registry of Births, Deaths and Marriages.	Temporary	Destroy 1 year after date of notification.
4.1.2		Register of Births within the hospital.	Permanent	Retain as State archives
4.1.3		Notification of deaths that have occurred in a public hospital or health service to the Registry of Births, Deaths and Marriages.	Temporary	Destroy 1 year after date of notification.
4.1.4		Register of Deaths within the hospital.	Permanent	Retain as State archives
4.2	**Reporting of Notifiable Diseases, Birth, Morbidity and Mortality Rates**	Reporting of notifiable diseases, birth, morbidity and mortality rates for public health policy and planning purposes.		
4.2.1		Reporting to Department responsible for public health of notifiable (infectious) disease cases and birth, mortality and morbidity rates.	Temporary	Destroy 6 months after date of notification.

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PROS 19/08 will apply unless existing retention periods in this RDA are greater than or equal to those specified in PROS 19/08.

Authority number: PROS 11/06 VAR 2

No	Function/Activity	Description	Status	Disposal Action
STATUTORY REPORTING AND MONITORING OF PATIENTS - Reporting of Suspected Criminal Activity				
4.3	**Reporting of Suspected Criminal Activity**	Reporting of suspected cases of child abuse and neglect; sexual and physical assault and injury suspected to be caused by criminal activity.		
4.3.1		Records documenting the reporting of child sexual abuse incidents or disclosures or any suspected cases of sexual abuse of children. Includes mandatory reports made to appropriate authorities.	Temporary	Destroy 99 years after action completed.
4.3.2		Records documenting the reporting of patients presenting with suspected injuries resulting from child abuse or neglect. Includes mandatory reports made to appropriate authorities. [does not include child sexual abuse - see 4.3.1]	Temporary	Destroy 15 years after date of last attendance, or access by or on behalf of the patient provided they have reached 30 years of age.
4.3.3		Records documenting reports made to appropriate authorities for adult patients presenting with suspected injuries suspected to be caused by criminal activity, including sexual assault or physical assault.	Temporary	Destroy 15 years after after date of last attendance, or access by or on behalf of the patient.
4.4	**Reporting of Treatment Regulated under the Mental Health Act**	Reporting to the Chief Psychiatrist of treatment provided to mental health patients as required under the *Mental Health Act* to enable the Chief Psychiatrist to be informed and act accordingly.		

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Authority number: PROS 11/06 VAR 2

No	Function/Activity	Description	Status	Disposal Action
STATUTORY REPORTING AND MONITORING OF PATIENTS - Reporting of Treatment Regulated under the Mental Health Act				
		[For treatment of mental health patients, see 2.0.0]		
4.4.1		Notifications of the use of patient seclusion, electroconvulsive therapy (ECT) or mechanical restraints in the treatment of mental health patients.	Temporary	Destroy 25 years after date of last attendance, or access by or on behalf of the patient provided they have reached 43 years of age.
4.4.2		Monthly returns of the use of electroconvulsive therapy (ECT), mechanical restraint and seclusion used in the treatment of mental health patients.	Temporary	Destroy 2 years after notification to Chief Psychiatrist.
4.5	**Protection of the Rights of Mental Health Patients**	The protection of the rights of mental health patients in accordance with the *Mental Health Act.*		
4.5.1		Statement of rights provided to patients and/or their appointed representative.	Temporary	Destroy 25 years after date of last attendance, or access by or on behalf of the patient provided they have reached 43 years of age.
4.5.2		Records documenting the annual examination of general physical and mental health made of all	Temporary	Destroy 25 years after date of last attendance,

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No	Function/Activity	Description	Status	Disposal Action
STATUTORY REPORTING AND MONITORING OF PATIENTS - Protection of the Rights of Mental Health Patients				
		involuntary mental health patients and reported to the Chief Psychiatrist to ensure: • that all involuntary patients have access to medical advice and treatment of non-mental health conditions (at no cost to the patient), and • that undiagnosed non-mental health conditions and/or physical side effects of mental health treatment regimes are not having a further deleterious effect on the mental health of the patient.		or access by or on behalf of the patient provided they have reached 43 years of age.
4.5.3		Records of visits made by a Community Visitor to a public hospital or health facility offering mental health services noting date, time and duration of visit. [For reports made by Community Visitors regarding their visits, see the *Retention & Disposal Authority for the Records of the Office of the PublicAdvocate*.]	Temporary	Destroy 7 years after date visit concluded.
4.5.4		Records documenting individual requests made by a patient to see a Community Visitor.	Temporary	Destroy 7 years after last action.
4.6	**Applications for Special Leave,**	The assessment of applications for special leave to security patients. Includes the submission of applications for forensic leave by forensic patients to		

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Authority number: PROS 11/06 VAR 2

No	Function/Activity	Description	Status	Disposal Action
STATUTORY REPORTING AND MONITORING OF PATIENTS - Applications for Special Leave, Forensic Leave and Leave of Absence				
	Forensic Leave and Leave of Absence	the Forensic Leave Panel. Also includes the submission of applications for leave of absence by security patients to the Department of Justice. [For Appeals to Mental Health Review Board, see 4.7.0]		
4.6.1		Records of applications for special leave made for security patients to the Chief Psychiatrist. Includes determinations.	Temporary	Destroy 15 years after determination made.
4.6.2		Applications for forensic leave made by forensic patients to the Forensic Leave Panel. Includes determinations and orders made by the Panel.	Temporary	Destroy 15 years after determination made.
4.6.3		Applications for leave of absence made by security patients to the Department of Justice. Includes determinations made by the Department.	Temporary	Destroy 15 years after determination made.
4.7	**Mental Health Review Board Applications**	Submission of applications to the Mental Health Review Board to: • review involuntary treatment orders, • review orders made for involuntary and security patients and their treatment plans,		

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No	Function/Activity	Description	Status	Disposal Action
STATUTORY REPORTING AND MONITORING OF PATIENTS - Mental Health Review Board Applications				
		• appeal the refusal to grant special leave to security patients, • appeal the transfer of involuntary and security patients, and • review orders for the transfer of involuntary patients to interstate mental health facilities. [For Records of the Mental Health Review Board, see *Retention and Disposal Authority for Records of Mental Health Review Board* PROS 05/05]		
4.7.1		Applications to the Mental Health Review Board to review orders and to appeal determinations. Includes the Boards reasons for final determination.	Temporary	Destroy 25 years after date of last attendance, or access by or on behalf of the patient provided they have reached 43 years of age.
4.8	**Mental Health Patient Trust Accounts Management**	The management of the Patient Trust Accounts in accordance with the requirements of the *Mental Health Act*.		
4.8.1		Account identification details for trust accounts established for each patient including details of the authorised deposit-taking institution, the patient	Temporary	Destroy 7 years after account closed.

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No	Function/Activity	Description	Status	Disposal Action
STATUTORY REPORTING AND MONITORING OF PATIENTS - Mental Health Patient Trust Accounts Management				
		trust account type, name, and numbers of the interest accounts and investment portfolios.		
4.8.2		Periodical transaction statements for each account.	Temporary	Destroy 7 years after the end of the financial year to which the statement applies.
4.8.3		Patient requests for withdrawal of funds.	Temporary	Destroy 7 years after the end of the financial year in which the request was made.
5	**DISCHARGING PATIENTS AND POST CARE**	Discharging a patient from a health service after completion of a treatment, or at the patient's request. [For notification of deaths, see 4.1.3]		
5.1	**Authorising Discharge**	The authorisation of patient discharge. Includes: • capturing information about the date the hospital or health facility ceases to have primary responsibility for the medical treatment and care of the patient,		

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No	Function/Activity	Description	Status	Disposal Action
DISCHARGING PATIENTS AND POST CARE - Authorising Discharge				
		• arranging for the transfer of custody where the patient is on a custodial, forensic or security order.		
5.1.1		Records authorising patient discharge either by a medical practitioner or by the patient. Includes formal discharge summary, and in the event of a patient death, the provision of a death certificate to next of kin /executors.	Temporary	Destroy 15 years after date of last attendance, or access by or on behalf of the patient provided they have reached 30 years of age.
5.1.2		Records authorising the discharge of patients in accordance with the *Mental Health Act*. Includes authorities to transfer and transport a patient a patient to another facility.	Temporary	Destroy 25 years after date of last attendance, or access by or on behalf of the patient provided they have reached 43 years of age.
5.2	**Post Care Arrangements and Instructions**	Post Care Arrangements and Instructions		
5.2.1		Instructions and arrangements upon discharge for patients, including;	Temporary	Destroy 15 years after date of last attendance, or access by or on behalf of the patient

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No	Function/Activity	Description	Status	Disposal Action
DISCHARGING PATIENTS AND POST CARE - Post Care Arrangements and Instructions				
		• arrangements for the collection of the patient, including any specialist transport required • instructions for medication, injury management, diet / exercise regimes, use of equipment , additional appointments • provision of referrals to provide to General Practitioner (GP) or specialist for ongoing treatment • medical certificate if required. [Excludes patients treated in accordance with the *Mental Health Act*, use 5.2.2.]		provided they have reached 30 years of age.
5.2.2		Instructions and arrangements upon discharge for patients treated under the *Mental Health Act* upon including: • arrangements for the collection of the patient, including any specialist transport required • instructions for medication • provision of referrals to provide to GP or specialist for ongoing treatment	Temporary	Destroy 25 years after date of last attendance, or access by or on behalf of the patient provided they have reached 43 years of age.

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No	Function/Activity	Description	Status	Disposal Action
ACCESS TO PATIENT INFORMATION				
		• medical certificate if required.		
6	**ACCESS TO PATIENT INFORMATION**	The management of access to patient information through requests by patients (or authorised representative) and to comply with legal processes such as subpoenas and warrants. Includes assessment of applications, determinations, and the arrangements for access to occur.		
6.1	**Assessment of Applications**	The assessment of requests for access to patient information. [For Freedom of Information (FOI) applications, use the *General Retention & Disposal Authority for Records of Common Administrative Functions*.]		
6.1.1		Records documenting requests to access to patient information. Includes determinations and patient consents.	Temporary	Destroy 5 years after action completed.
7	**STERILISATION OF MEDICAL EQUIPMENT**	The sterilisation, disinfecting and cleaning of reusable medical and surgical instruments and equipment for infection prevention and control.		
7.1	**Sterilisation, Cleaning and Disinfection of**	The recording of the cleaning, disinfection and sterilisation of reusable medical equipment that are used for patient treatment and care.		

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No	Function/Activity	Description	Status	Disposal Action
STERILISATION OF MEDICAL EQUIPMENT - Sterilisation, Cleaning and Disinfection of Reusable Medical Equipment				
	Reusable Medical Equipment			
7.1.1		Sterilisation records that identify individual patients.	Temporary	Destroy 15 years after action complete.
7.1.2		Sterilisation records that do not identify individual patients.	Temporary	Destroy after when action complete.
8	**PATIENT TRANSPORT SERVICE**	The management of transport services for non-emergency patients. Excludes emergency ambulance services. For records documenting emergency ambulance services or any clinical information about transported patients held by Ambulance Victoria, see *PROS 17/02 Retention and Disposal Authority for Records of the Emergency Services Function*.		

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No	Function/Activity	Description	Status	Disposal Action
PATIENT TRANSPORT SERVICE - Non-emergency transport service provision				
8.1	**Non-emergency transport service provision**	The provision of non-emergency transport services for patients, such as transport to medical appointments and transporting patients between hospitals. Includes the Clinic Transport Service.		
8.1.1		Records documenting booking forms requesting the transport service. Records can include patient name, address, appointment date, time and location. Excludes clinical information.	Temporary	Destroy 2 years after last action.