Updated to November 30, 2024
This document has official status.

chapter S-4.2, r. 23

Regulation respecting the information that institutions must provide to the Minister of Health and Social Services

Act respecting health services and social services
(chapter S-4.2, s. 505).

TABLE OF CONTENTS

1. In this Regulation,

(1) "individual user" means any person who benefits from interventions on an individual basis;

(2) "group user" means a group of persons in a similar situation that benefits from interventions of a preventive, therapeutic, educational, supportive or other nature during a specific period of time;

(3) "community user" means a population group covered by a project or sharing common objectives and that benefits from community interventions.

O.C. 103-2009, s. 1.

2. An institution operating a local community service centre must provide the Minister with the information in Schedule I in respect of an individual user, a group user or a community user that receives services from such a centre.

O.C. 103-2009, s. 2.

3. A public institution or a private institution under agreement operating a residential and long-term care centre must provide the Minister with the information in Schedule II in respect of a user enrolled or admitted to receive the services offered in such a centre, unless the user occupies a bed classified as a mental health bed according to the institution's permit.

O.C. 103-2009, s. 3.

4. An institution operating an emergency department must provide the Minister with the information in Schedule III in respect of a user enrolled to receive emergency services.

O.C. 103-2009, s. 4; O.C. 732-2011, s. 3.

5. An institution operating a hospital centre must provide the Minister with the information in Schedule IV in respect of a user admitted to receive general or specialized care, including psychiatric care, according to the class of the hospital centre operated by the institution, and in respect of a user enrolled for day surgery provided for in the financial management manual published by the Minister under section 477 of the Act respecting health services and social services (chapter S-4.2).

O.C. 103-2009, s. 5.

5.1. An institution operating a hospital of the general and specialized class of hospitals and a trauma centre must provide the Minister with the information in Schedule V in respect of a user who is a trauma patient and is admitted to or dies in the emergency department.

O.C. 732-2011, s. 1.

5.1.1. An institution operating a hospital of the general and specialized class of hospitals and offering oncology services must provide the Minister with the information in Schedule V.1 in respect of a user suffering from cancer who receives such services.

O.C. 759-2019, s. 1.

5.1.2. An institution operating a hospital of the general and specialized class of hospitals and offering renal replacement services must provide the Minister with the information in Schedule V.2 in respect of the following users:

(1) every user to whom the institution provided the first dialysis treatment;

(2) every user for whom the institution performs the monitoring of dialysis treatments;

(3) every user to whom the institution provides renal replacement services who is transferred to another facility or whose treatment has changed or stopped.

Despite the first paragraph of section 108.2 of the Act, the information is provided only by the institution that physically provides services to a user.

O.C. 759-2019, s. 1.

5.1.3. An institution operating a hospital of the general and specialized class of hospitals in which a clinical department of laboratory medicine is established must provide the Minister with the information in Schedule V.3 in respect of the following users:

(1) every user for whom an examination of the immunochemical fecal occult blood test is carried out;

(2) every user for whom an examination of the human papillomavirus test is carried out.

O.C. 317-2022, s. 1.

5.2. An institution operating both a child and youth protection centre and a rehabilitation centre of the rehabilitation centre class for young persons with adjustment problems must provide the Minister with the information required under Schedule VI, provided that the information cannot be connected with a user of the institution.

O.C. 719-2012, s. 1; O.C. 859-2018, s. 1.

5.2.1. A public institution or a private institution under agreement operating one of the following centres must provide the Minister with the information in Schedule VI.1 in respect of a user who receives rehabilitation services from such a centre:

(1) a rehabilitation centre of one of the following classes:

(a) a rehabilitation centre for mentally impaired persons or persons with a pervasive developmental disorder;

(b) a rehabilitation centre for physically impaired persons;

(2) a hospital of the general and specialized class of hospitals.

O.C. 759-2019, s. 2; O.C. 317-2022, s. 2.

5.2.2. A public institution operating a rehabilitation centre belonging to the class of rehabilitation centres for persons with an addiction must provide the Minister with the information in Schedule VI.2 in respect of an individual user or a group user that receives services from such a centre.

O.C. 317-2022, s. 2.

5.3. Every public institution or private institution under agreement must provide the Minister with the information in Schedule VII in respect of the following users, provided that the institution collects the information:

(1) every elderly person for whom the institution conducted the identification of a loss of autonomy or received an identification of loss of autonomy form duly completed, whether or not the identification actually shows a loss of autonomy;

(2) every user of full age or user who is an emancipated minor for whom the institution conducted the assessment of a loss of autonomy using recognized tools, whether or not the assessment actually shows a loss

of autonomy, or to whom the institution provides services by reason of significant and persistent disabilities, even if no prior identification or assessment was conducted.

O.C. 753-2014, s. 1.

6. An institution referred to in sections 2 to 5.1.1, 5.1.3 and 5.2.1 to 5.3 must also provide the Minister with the following information:

(1) concerning the identity of an individual user:

(a) name;

(b) health insurance number;

(c) sex;

(d) date of birth;

(e) residence postal code;

(f) the code of the municipality where the user's residence is located;

(2) the file number of any type of user; and

(3) the date on which each particular is first provided and the date on which it is updated.

In the case of a user admitted to the facility of an institution referred to in section 3 or enrolled for the services of that institution, the postal code required under subparagraph *e* of subparagraph 1 of the first paragraph is the code of the place where the user is residing or staying when a care and service program begins.

O.C. 103-2009, s. 6; O.C. 732-2011, s. 4; O.C. 753-2014, s. 2; O.C. 759-2019, s. 3; O.C. 317-2022, s. 3.

6.1. Despite sections 2 to 5.3, the institutions referred to therein are required to provide the information prescribed therein only from the moment they have access to the information asset indicated by the Minister.

O.C. 753-2014, s. 3.

7. *(Omitted).*

O.C. 103-2009, s. 7.

SCHEDULE I

1. An institution referred to in section 2 of the Regulation must provide the following information in respect of any type of user of the services of a local community service centre:

(1) concerning each request for services:

(a) sequence number;

(b) date of receipt;

(c) origin;

(d) object;

(e) the centre or sub-centre of activities concerned;

(f) the decision rendered after examination of the request and the date of the decision;

(g) an indication that it is an individual, couple, family, group or community request;

(h) the priority code assigned to the request;

(2) indication of the type of user;

(3) concerning each sporadic intervention or activity:

(a) sequence number;

(b) the centre or sub-centre of activities concerned;

(c) date

(d) type;

(e) the reasons therefor;

(f) any act performed by the provider;

(g) follow-up;

(h) the master program to which it is related;

(h.1) the intervention program to which it is related;

(i) mode;

(j) the place of the intervention or activity;

(k) in the case of an intervention, the duration;

(l) the language used during the intervention or activity;

(m) the provider's class of employment and link with the institution;

(n) the number of providers participating in the intervention or activity;

(o) if the intervention or activity is performed in a school environment, the education level;

(p) if the intervention or activity is intended for a group user, the number of participants;

(4) concerning each episode of service rendered to a user:

(a) the sequence number;

(b) the dates on which the service begins and ends;

(c) the sequence number of its assignment to a centre or sub-centre of activities;

(d) the centre or sub-centre of activities covered by the assignment;

(e) the dates on which the assignment begins and ends;

(e.1) the priority code assigned to the assignment;

(f) the sequence number associated to each period of the user's unavailability;

(g) the dates on which the user's unavailability begins and ends;

(h) the date on which services will be required for the user at a later date;

(i) the reason for interrupting the service episode.

2. In addition to the information required under section 1, an institution referred to in section 2 of the Regulation must provide the following information:

(1) concerning an individual user:

(a) the reason for which the user's health insurance number cannot be provided, where applicable;

(b) the province or territory responsible for the health care insurance plan insuring the user;

(c) the date on which the user's file was opened;

(d) the code of the territory of the local community service centre where the user's residence is located;

(e) the user's overall deprivation;

(f) the user's material deprivation;

(g) the user's social deprivation;

(2) concerning the specific services rendered to an individual user in perinatal care:

(a) the sequence number of the service;

(b) the service for which the user is enrolled;

(c) the dates on which enrolment for the service begins and ends;

(d) the reason for interrupting enrolment for the service;

(e) the gestational age at the time of enrolment, where applicable;

(f) the immediate social environment of the user;

*(f.*1*)* an indication of whether the user is socially isolated;

(g) the financial situation of the user at the time of enrolment, whether below or above the low income after-tax cut-off defined by Statistics Canada;

(h) the level of schooling of the user at the time of enrolment;

(i) whether the user is a Native;

(j) whether the user is an immigrant who has lived in Canada for 5 years or less;

(k) the prenatal or postnatal gravida, para and aborta, according to the time of enrolment;

(l) the date and time of delivery;

(m) the duration of the pregnancy at the time of delivery;

(n) the number of live births and stillbirths at the time of delivery;

(o) the infant's weight in grams at birth;

(p) (subparagraph revoked);

(q) if the user was subject to a transfer of clinical responsibility from a midwife to another type of professional:

i. an indication of the prenatal, intrapartum or postnatal transfer of the mother or baby;

ii. the date of the transfer;

iii. an indication whether or not the transfer was urgent;

iv. the reason for the transfer;

v. the place of origin of the transfer;

vi. the sequence number assigned to the transfer;

(r) the method of entering into labour;

(s) the duration of latency;

(t) the duration of active labour;

(u) the duration of pushing;

(v) the duration of placenta delivery;

(w) the total duration of delivery;

(x) the place of delivery;

(y) the type of professional under whose responsibility delivery was performed;

(z) the type of delivery;

(aa) whether or not a vacuum was used during delivery;

(bb) whether or not an episiotomy was performed during delivery;

(2.1) concerning any service rendered to an individual user in perinatal care, the type of food consumed by the child;

(3) *(paragraph revoked);*

(4) the category and target population of the group user;

(5) the category, target population and main activities of the community user.

3. Every transmission of the information required under sections 1 and 2 must be accompanied by the following:

(1) the code of the health region from which the information originates;

(2) the permit number of the institution providing the information;

(3) the date of transmission;

(4) the number assigned to the transmission;

(5) the dates on which the period concerned begins and ends.

O.C. 103-2009, Sch. I; O.C. 759-2019, s. 4; O.C. 317-2022, s. 4.

SCHEDULE II

1. Where a care and service program is implemented for a user, an institution referred to in section 3 of the Regulation must provide the following information:

(1) concerning the user:

(a) civil status;

(b) ethnic or cultural group;

(c) language of communication used in daily activities;

(d) religion;

(e) the method of management of the user's property;

(f) the date and place of death, where applicable;

(2) concerning the services rendered to a user who benefits from a care and service program:

(a) the date on which the program is determined;

(b) the date on which the program begins for the user following registration of the user's presence;

(c) the program applied to the user;

(d) the master program to which the user's program is linked;

(e) if the user is registered for the "day centre" or "day hospital" programs:

i. the days of the week and, for each day, the time of day during which interventions are planned as part of the program;

ii. the method of transportation used each day by the user to benefit from the program, whether or not the transportation is provided by the institution;

(f) the type of resource providing the program;

(g) if the program is interrupted:

i. the date of and reason for the interruption;

ii. if the interruption lasts more than one day, the date on which the user resumes the program;

(h) the date on which the program is terminated and the reason for termination;

(3) concerning the departure point and destination of a user who benefits from a care and service program:

(a) the place and code of the municipality where the user is residing or staying at the beginning and end of the program;

(b) the postal code of the place where the user is residing or staying at the end of the program;

(c) any other program in which the user participated before the beginning of the program;

(d) the person or organization that made the application leading to the determination of the program;

(e) the program and the person or organization to which the user is referred at the end of the program;

(4) concerning each diagnosis made in respect of a user during the period of participation in a care and service program:

(a) the date of any assessment;

(b) the diagnosis according to the International Statistical Classification of Diseases and Related Health Problems, Tenth Revision, expanded by the Canadian Institute for Health Information (ICD-10-CA);

(c) the type of diagnosis;

(d) the date of the diagnosis;

(5) concerning any prescribed medication administered to a user in an institution referred to in section 3 of the Regulation during the period of participation in a care and service program:

(a) the date on which the medication is first administered;

(b) the identification number of the prescribed medication identified in the list of medications-institutions, except for medications collectively prescribed;

(c) the date on which the medication ends;

(6) concerning any accident or incident suffered by a user during the period of participation in a care and service program:

(a) the date, place and time of the accident or incident that caused the trauma or adverse effect suffered by the user;

(b) the cause of the accident or incident and a description thereof;

(c) the circumstances preceding the accident or incident and a description of the facts:

i. the type of situation preceding the accident orincident;

ii. the mental state of the user before the accident or incident;

iii. the mobility of the user before the accident or incident;

iv. the level of supervision needed by the user before the accident or incident;

v. the factors which might have contributed to the accident or incident;

vi. the physical environment before the accident or incident which might have had an influence on its occurrence;

vii. the configuration of the bed at the time of the accident or incident;

(d) the repercussions of the event on the user which make it possible to determine whether it is an accident or incident;

(e) the opinion of the provider on a possible claim by the user following the accident or incident;

(7) concerning any control measure applied to a user:

(a) the type of control measure applied;

(b) the date on which the control measure begins;

(c) the reason for the control measure;

(d) the category of professional who decided to use the control measure;

(e) the total number of hours per day during which the user is subject to the control measure;

(f) the date on which the control measure ends;

(8) concerning any transmission of information to the Minister:

(a) the code of the transmitting facility;

(b) the permit number of the institution providing services to the user;

(c) the number of the facility on the permit of the institution providing services to the user;

(d) the date of transmission;

(e) the number assigned to the transmission;

(f) the dates on which the period concerned begins and ends.

O.C. 103-2009, Sch. II.

SCHEDULE III

1. An institution referred to in section 4 of the Regulation must provide the following information:

(1) concerning the user:

(a) the code of the municipality where the user's residence is located;

(b) the reason why the user's health insurance number cannot be provided, if applicable;

(b.1) an indication that the user was taken to the institution against his or her will by a peace officer under section 8 of the Act respecting the protection of persons whose mental state presents a danger to themselves or to others (chapter P-38.001), where applicable;

(c) the date, hour, minute and second of the user's death, if applicable;

(d) whether a coroner intervened following the user's death;

(e) whether an autopsy was requested following the user's death;

(2) concerning any period of care to the user at the emergency department:

(a) the number identifying the period;

(b) the date, hour, minute and second of the beginning of the period;

(c) how the user arrived at the emergency department;

(d) the user's age at the time of the period;

(e) the major category of the diagnosis;

(f) the reason for the user's visit to the emergency department;

(g) the diagnosis;

(h) whether there is a family physician and a referring physician;

(i) the number of the form to declare transportation by ambulance, if applicable;

(i.1) the date, hour, minute and second of the end of the brief assessment;

(i.2) the priority code assigned to the brief assessment;

(j) the date, hour, minute and second of the end of the first triage;

(k) the priority code assigned at the first triage;

(l) the user's autonomy after the first triage;

(m) the date, hour, minute and second of the first taking in charge, if applicable;

(n) the date, hour, minute and second of the first application for admission, cancelled or not, if applicable;

(o) the clinical service of the last application for admission, cancelled or not, if applicable;

(p) the date, hour, minute and second when the user left the emergency department;

(q) the user's destination when leaving the emergency department;

(r) the reason for the user's transfer to another facility, if applicable, and, if the user is transferred because of an unavailable service, the priority assigned to the user's transfer;

(s) if the user comes from another facility, the number of that facility on the institution's permit;

(t) if the user is transferred to another facility, the number of the receiving facility on the institution's permit;

(3) concerning any consultation by the user during a period of care at the emergency department:

(a) the date, hour, minute and second of the creation of the consultation;

(b) the date, hour, minute and second of the request for consultation;

(c) the date, hour, minute and second of the return of the call by the medical consultant;

(d) the specialty code of the medical consultant;

(e) the medical specialty concerned;

(f) the service requested;

(g) the state of realization of the consultation;

(h) the number of the consultation;

(i) the priority code assigned to the consultation;

(4) concerning the occupation of a stretcher by the user during the period of care:

(a) the date, hour, minute and second of the beginning of the first period of occupation;

(b) the date, hour, minute and second of the end of the last period of occupation;

(c) the category of the first period of occupation;

(5) concerning any transmission of information to the Minister:

(a) the number of the data extraction;

(b) the date, hour, minute and second of the data extraction;

(c) the number on the institution's permit of the facility to which the emergency department is linked;

(6) concerning the occupation of a chair by the user in the quick assessment zone as part of a period of care at the emergency department, where applicable:

(a) the date, hour, minute and second of the beginning of the first period of occupation;

(b) the date, hour, minute and second of the last period of occupation;

(7) concerning any request for a diagnostic test by the user as part of a period of care at the emergency department:

(a) the date, hour, minute and second of the request for a diagnostic test;

(b) the date, hour, minute and second of the beginning of the diagnostic test;

(c) the state of realization of the diagnostic test;

(d) the type of diagnostic test;

(e) the priority code assigned to the request for a diagnostic test.

O.C. 103-2009, Sch. III; O.C. 859-2018, s. 2.

SCHEDULE IV

1. An institution referred to in section 5 of the Regulation must provide the following information:

(1) concerning the user:

(a) whether the user is a newborn;

(b) the code of the municipality where the user's residence is located;

(c) the place of birth;

(d) the code corresponding to the user's occupation;

(e) the user's civil status;

(f) if the user died, the immediate cause of death according to ICD-10-CA, the type of death and whether there was an autopsy or an investigation by a coroner;

(2) concerning the accident that led to the user's hospitalization, if applicable:

(a) the date of the accident;

(b) the code corresponding to the external cause of the accident according to ICD-10-CA;

(c) the code corresponding to the place of the accident according to ICD-10-CA;

(3) concerning the origin, admission and destination of the user:

(a) the code of the facility of origin;

(b) the type of origin;

(c) the date and time of admission;

(d) the type of admission;

(e) the diagnosis at admission according to ICD-10-CA;

(f) the type of care provided;

(g) if the user is transferred directly from the emergency department of the institution to a short-term care unit or day surgery in the same institution, the date of registration for the emergency department;

(h) the person responsible for paying the hospital stay;

(i) the date and time of leaving the facility where the care was provided;

(j) the number of days of temporary leave;

(k) the number of hospitalization days;

(l) the code of the facility that is the destination;

(m) the type of destination;

(4) the diagnosis according to ICD-10-CA;

(5) concerning any stay of the user in a service where care was provided, and any diagnosis made there:

(a) the code of the service;

(b) the type of stay;

(c) the residency status and specialty of the attending physician;

(d) the diagnosis of the affection justifying the user to stay in the service according to ICD-10-CA and the characteristic of the diagnosis;

(e) the duration of the stay in the service;

(f) the dates of the beginning and end of each type of stay;

(6) concerning any affection other than those referred to in paragraph 2 or 5 diagnosed or treated during the user's hospitalization:

(a) the main diagnosis according to ICD-10-CA;

(b) the service in which the affection was diagnosed or treated and the characteristic of the diagnosis;

(7) concerning any medical consultation by the user during hospitalization:

(a) the service from which the request for consultation originates;

(b) the field of the consultation;

(c) the specialty of the medical consultant;

(8) the total number of consultations by the user;

(9) concerning any intervention on the user during hospitalization:

(a) the service for which the user is enrolled;

(b) the date, time and place of the intervention;

(c) the intervention code according to the Canadian Classification of Health Interventions (CCI);

(d) the status attribute of the intervention according to the CCI;

(e) the location attribute of the intervention according to the CCI;

(f) the extent attribute of the intervention according to the CCI;

(g) the number of times an intervention was performed;

(h) the residency status and specialty of the physician who performed an intervention or administered ananesthesia;

(i) the anaesthesia technique used, where applicable;

(j) the date and time the user left the operating room, where applicable;

(10) concerning any stay of the user in an intensive care unit:

(a) the code of the intensive care unit;

(b) the duration of the stay;

(11) concerning a user who received services following a birth or stillbirth:

(a) the number of stillbirths following the pregnancy concerned, if applicable;

(b) the number of stillbirths that led to an autopsy following the pregnancy concerned, if applicable;

(c) the weight in grams of a product of conception of more than 100 grams in the case of a live birth or of more than 500 grams in the case of a stillbirth;

(d) the duration of the pregnancy;

(12) concerning any transmission of information to the Minister:

(a) the financial period concerned;

(b) the type of transaction;

(c) the date of transmission;

(d) the admission number;

(e) the number of the facility on the institution's permit where care was provided.

An institution referred to in section 5 of the Regulation must also provide the information in subparagraph *c* of subparagraph 11 of the first paragraph for any user born in a facility of the institution or who was admitted there within 28 days of birth.

The institution must also provide the information in subparagraph *d* of subparagraph 11 of the first paragraph for any user born in a facility of the institution, including the number of the mother's medical record.

2. In addition to the information required under section 1, an institution referred to in section 5 of the Regulation that makes a tumour diagnosis must provide the following information:

(1) concerning the user: the name of the mother at birth and the name of the father;

(2) concerning any diagnosed tumour of the user: its topography according to ICD-10-CA, its morphology according to the International Classification of Diseases: oncology, 1st Edition (ICD-O-3) and how the tumour was diagnosed.

O.C. 103-2009, Sch. IV; O.C. 859-2018, s. 3.

SCHEDULE V

(s. 5.1)

1. An institution referred to in section 5.1 of the Regulation must provide the following information:

(1) concerning the user and the traumatic event:

(a) the name and number, on the institution's permit, of the facility that provides the data;

(b) the sequence number assigned to the traumatic event;

(c) the code of the municipality where the user's residence is located;

(d) the geographic code of the user's residence;

(e) the reason for which the health insurance number cannot be provided, where applicable;

(f) the date and time of the trauma;

(g) the code of the municipality where the trauma occurred;

(h) the geographic code of the place where the trauma occurred;

(i) the cause of the trauma;

(j) the place where the trauma occurred;

(k) an indication that the trauma occurred when the user was at work;

(l) the external cause responsible for the trauma according to ICD-10-CA;

(m) the activity carried on by the user when the trauma occurred, according to ICD-10-CA;

(n) the type of medical insurance under which the user is compensated;

(o) the user's role at the time of the trauma;

(p) the safety equipment used or worn by the user at the time of the trauma, where applicable;

(2) concerning the delivery of pre-hospital emergency services to the user or collected during delivery:

(a) the date and time of reception, at the health communication centre, of the call from a 9-1-1 emergency centre requesting the intervention of pre-hospital emergency services;

(b) the method of transportation to the first facility of the institution where the user was received;

(c) the date and time of arrival of the first responder at the user's side, where applicable;

(d) the date and time of arrival of the ambulance at the scene of the trauma;

(e) the date and time of departure of the ambulance from the scene of the trauma;

(f) the distance travelled by the ambulance, in kilometers, between the scene of the trauma and the first installation where the user was received;

(g) the number of the form to declare transportation by ambulance;

(h) the number of the pre-hospital intervention report;

(i) an indication that the user had to be extricated from a vehicle that had been in an accident;

(j) an indication that the Échelle québécoise de triage préhospitalier en traumatologie was used;

(k) the criterion used to direct the user to the first facility under the Échelle québécoise de triage préhospitalier en traumatologie;

(l) the score on the GCS (Glasgow Coma Scale);

(m) an indication that there was immobilization of the user's rachis or spine;

(n) the user's respiratory rate;

(o) the user's pulse;

(p) the user's systolic blood pressure;

(q) the date and time of any cardiorespiratory arrest;

(r) an indication that oxygen was used;

(s) the user's percentage of oxygen saturation;

(t) an indication that respiratory support, ventilatory support, a combitube or a neck brace was used;

(u) the name and number, on the institution's permit, of the first facility where the user was received;

(v) the date and time of arrival at that facility;

(w) the number of the user's record at the first facility where the user was received;

(3) concerning the user's visits to any emergency department and any consultation requested therein:

(a) the method of transportation to the emergency department;

(b) the user's origin upon arrival in the emergency department;

(c) the name and number, on the institution's permit, of the facility of origin upon arrival in the emergency department, where applicable;

(d) the name and number, on the institution's permit, of the facility where emergency care was provided to the user;

(e) the date and time of the user's arrival in the emergency department;

(f) an indication that the user was alive or dead upon arrival in the emergency department;

(g) the sequence number assigned to the consultation;

(h) the field of consultation;

(i) the date and time of the request for consultation;

(j) the date and time of the consultation;

(k) the date and time of the user's departure from the emergency department;

(l) the user's destination upon departure from the emergency department;

(m) the name and number, on the institution's permit, of the facility that is the user's destination upon departure from the emergency department, where applicable;

(4) concerning the user's admission to and departure from the institution that provides the data:

(a) the method of transportation to the institution where the user was admitted;

(b) the user's origin upon admission;

(c) the name and number, on the institution's permit, of the user's facility of origin upon admission, where applicable;

(d) the date and time of the user's admission;

(e) an indication that the user was transferred to an institution in the user's region of origin for continuity of care;

(f) the sequence number assigned to any service the user was registered for;

(g) the code and description of any service the user was registered for;

(h) the date and time of registration of the user for any service;

(i) an indication that the user was brought directly to the surgical suite upon admission;

(j) the sequence number assigned to any physical care unit in which the user stayed;

(k) a description of the physical care unit in which the user stayed;

(l) the date and time of the user's arrival at any physical care unit in which the user stayed;

(m) the date and time of the user's departure from any physical care unit in which the user stayed;

(n) the date of any application for the user's transfer to another institution operating a hospital of the general and specialized class of hospitals;

(o) the date and time of the user's departure from the institution;

(p) the user's destination upon departure from the institution;

(q) the name and number, on the institution's permit, of the facility that is the user's destination upon departure from the institution, where applicable;

(5) concerning any taking of the user's vital signs in any emergency department or during the user's stay in the institution;

(a) the date and time the user's vital signs were taken;

(b) the degree of eye opening;

(c) the user's verbal response;

(d) the user's motor response;

(e) the score on the GCS (Glasgow Coma Scale);

(f) an indication that the user's level of consciousness was artificially modified;

(g) the type of modification of the user's level of consciousness;

(h) the user's type of respiration;

(i) the user's number of respiratory cycles per minute;

(j) the user's pulse;

(k) the user's systolic blood pressure;

(l) the user's diastolic blood pressure;

(m) an indication that oxygen was administered to the user;

(n) the user's percentage of oxygen saturation;

(o) the user's body temperature;

(p) the score on the RTS (Revised Trauma Score) physiological scale;

(q) the user's intracranial pressure;

(6) concerning any examination requested for the user or any intervention carried out for the user in any emergency department or during the user's stay in the institution:

(a) an indication that a radiographic assessment of the user was conducted;

(b) an indication that alcohol intoxication was suspected;

(c) the result of an alcohol intoxication test;

(d) the result of a drug intoxication test;

(e) the date and time a chest drain was inserted;

(f) the date and time of a FAST (Focused Assessment with Sonography in Traumatology);

(g) the date and time an intravenous line was inserted;

(h) the date and time of an intubation;

(i) the date and time of a gasometry;

(j) the date and time of a lactate measurement;

(k) the sequence number assigned to a medical imaging test;

(l) the type of medical imaging test requested for the user;

(m) the part of the user's body for which a medical imaging test was requested;

(n) the date and time of the request for a medical imaging test;

(o) the date and time a medical imaging test was conducted;

(p) the sequence number assigned to an intervention;

(q) the code and description of an intervention according to the CCI;

(r) the codes of the status, location and extent attributes of an intervention according to the CCI;

(s) the number of interventions carried out for the user;

(t) the date and time of an intervention;

(u) the place where an intervention was carried out;

(v) the date and time of the user's departure from the operating room, where applicable;

(w) the sequence number assigned to mechanical ventilation treatment;

(x) the date and time of the start of mechanical ventilation treatment;

(y) the date and time of the end of mechanical ventilation treatment;

(z) the paramedical consultations conducted for the user;

(aa) the date and time of the first paramedical consultation;

(7) concerning any diagnosis established for the user, as well as the user's death, where applicable:

(a) the sequence number assigned to the AIS (Abbreviated Injury Scale) code;

(b) the AIS code identifying each injury that was diagnosed;

(c) the diagnoses established according to ICD-10-CA;

(d) an indication that there was penetrating trauma and the part of the body affected;

(e) the result of the computation of the ISS (Injury Severity Score);

(f) the result of the computation of the PS_ISS (Probability of Survival Injury Severity Score);

(g) the result of the computation of the NISS (New Injury Severity Score);

(h) the presence of craniocerebral trauma (CCT) and the severity of that trauma;

(i) the presence, in the user, of a medullary injury and the type of medullary injury;

(j) the sequence number assigned to the complications presented by the user;

(k) the code and description of a complication according to ICD-10-CA;

(l) the sequence number assigned when comorbidity was registered for the user;

(m) the nature of the comorbidity;

(n) an indication that an autopsy of the user was conducted;

(o) an indication that it is a coroner's case where there is reason to notify the coroner under the Coroners Act (chapter C-68.01);

(p) an indication that organs were removed for donation;

(8) concerning users who are serious burn victims:

(a) the circumstances surrounding the user's burn or burns;

(b) the type of burns and a description of the burns;

(c) the user's colour or ethnic origin;

(d) the user's occupation;

(e) the user's weight upon arrival at the facility and upon departure from that facility;

(f) an indication that the user has inhaled fumes that may be made of corrosive or toxic gases;

(g) the user's carboxyhaemoglobin level;

(h) an indication that the use of a cell culture was necessary;

(i) an indication that the user had already suffered burns prior to the traumatic event;

(j) an indication that the user underwent a skin graft during the user's stay at the facility;

(k) an indication that the user was infected with MRSA (methicillin-resistant Staphylococcus aureus);

(l) an indication that the user was infected with VRE (vancomycin-resistant Enterococci);

(m) an indication that an agent was used to increase pressure in the user's blood vessels (vasopressor);

(n) specific interventions carried out for the user.

O.C. 732-2011, s. 2; O.C. 859-2018, s. 4.

SCHEDULE V.1

(s. 5.1.1)

1. The institution referred to in section 5.1.1 must provide the following information in respect of any user suffering from cancer:

(1) concerning the user:

(a) the name of the user's mother;

(b) the name of the user's father;

(c) if the user died:

i. the date of death;

ii. the province, territory or country where the user died;

iii. the number, on the institution's permit, of the facility where the user died or, failing that, the number of the institution that maintains the facility, where applicable;

(2) concerning a user diagnosed with cancer:

(a) the date of the diagnosis;

(b) the number, on the institution's permit, of the facility where the diagnosis is established or, failing that, the number of the institution that maintains the facility;

(c) the name and code of the municipality where the user's residence is located at the time of the diagnosis;

(d) the methods used to establish and confirm the diagnosis;

(e) the class assigned to a cancer case, according to the place of diagnosis and treatment;

(f) the behaviour of the tumor according to the International Classification of Diseases for Oncology (ICD-O);

(g) the tumor grade according to the clinical evaluation and the pathological evaluation, and after the post neoadjuvant treatment, where applicable, according to the classification of the North American Association of Central Cancer Registries or, if the cancer was diagnosed before 2018, the grade of the tumor according to the ICD-O;

(h) the histology of the tumor according to the ICD-O;

(i) the presence or absence of lymphovascular invasion;

(j) the tumor laterality;

(k) the topography of the primary site of the tumor according to the ICD-O;

(3) concerning a user diagnosed with colorectal, lung, prostate or breast cancer:

(a) according to the clinical evaluation and the pathological evaluation of the tumor carried out before the first line of treatment, where applicable, according to the classification of the Cancer Staging Manual of the American Joint Committee on Cancer:

i. the evaluation of the size or extension of the tumor;

ii. the observation of the presence or absence of regional lymph node metastases and the extension of their effect;

iii. the observation of the presence or absence of distant metastases;

iv. the TNM stage (Tumor Node Metastasis) of the tumor;

v. the specifications made by adding a suffix to the evaluation of the size or extension of the tumor and to the observation of the presence or absence of regional lymph node metastases and the extension of their effect or, if the cancer was diagnosed before 2018, the specifications made by adding a prefix or a suffix to the TNM stage;

(b) regarding the evaluation carried out after the post neoadjuvant treatment, where applicable:

i. the evaluation of the size or extension of the tumor;

ii. the observation of the presence or absence of regional lymph node metastases and the extension of their effect;

iii. the observation of the presence or absence of distant metastases;

iv. the TNM stage of the tumor;

v. the specifications made by adding a suffix to the evaluation of the size or extension of the tumor and to the observation of the presence or absence of regional lymph node metastases and the extension of their effect;

(c) an indication that the cancer is treated, not treated or under active supervision;

(4) concerning a user diagnosed with prostate cancer, the value of the prostate specific antigen test;

(5) concerning a user diagnosed with breast cancer:

(a) summaries of test results of estrogen receptors, progesterone receptors and the human epidermal growth factor receptor 2 of the tumor;

(b) the result of the Oncotype DX Breast Recurrence Score test;

(6) concerning the treatment of colorectal, lung, prostate or breast cancer:

(a) the date on which the first line of treatment begins;

(b) the date of the first surgical procedure, where applicable;

(c) regarding the most important surgical resection performed on the primary site of the cancer, where applicable:

i. the date of the intervention;

ii. the number, on the institution's permit, of the facility where the intervention was performed or, failing that, the number of the institution that maintains the facility;

iii. the type of surgical procedure performed;

iv. the state of surgical margins after the intervention;

(d) regarding administered radiotherapy treatment, where applicable:

i. the date on which the treatment begins;

ii. the number, on the institution's permit, of the facility where the treatment was administered or, failing that, the number of the institution that maintains the facility;

iii. the anatomic target of the treatment;

(e) regarding administered chemotherapy, hormonal therapy or immunotherapy treatment, where applicable :

i. the date on which the treatment begins;

ii. the number, on the institution's permit, of the facility where the treatment was administered or, failing that, the number of the institution that maintains the facility;

(f) regarding administered palliative treatment, where applicable:

i. the type of treatment administered;

ii. the number, on the institution's permit, of the facility where the treatment was administered or, failing that, the number of the institution that maintains the facility.

2. An institution referred to in section 5.1.1 of the Regulation must provide the following information in respect of any user for whom a request for a radiation oncology consultation is made or to whom radiation oncology treatment is administered:

(1) the date of receipt of the request for consultation;

(2) the clinical priority code assigned to the user's cancer;

(3) the date of the first consultation;

(4) an indication that the administration of radiotherapy treatment was deemed appropriate following the consultation;

(5) the date as of which the user is deemed ready to receive a first radiotherapy treatment;

(6) regarding the radiotherapy treatment administered or determined following the consultation:

(a) the date on which it is administered for the first time;

(b) its anatomic target;

(c) an indication of whether it is teletherapy treatment or brachytherapy treatment;

(d) in the case of teletherapy treatment, the planning technique used in accordance with the financial management manual published by the Minister under section 477 of the Act respecting health services and social services (chapter S-4.2);

(e) the name of the treatment plan;

(f) an indication of whether the treatment is curative or palliative;

(g) the number of treatment fractions scheduled;

(7) for each period of the user's unavailability:

(a) the dates on which the user's unavailability begins and ends;

(b) an indication of whether the unavailability is due to personal or medical reasons;

(8) the explanations of the institution regarding any delays incurred and any period of unavailability reported.

3. An institution referred to in section 5.1.1 of the Regulation must provide the following information in respect of any user for whom a request for an oncology consultation or a hematology consultation is made or to whom oncology or hematology treatment is administered:

(1) the date of receipt of the request for consultation;

(2) the priority code assigned to the request;

(3) the date of the first consultation;

(4) the tumour site of the cancer concerned by the treatment, where applicable;

(5) if the request for consultation concerns a user whose cancer diagnosis has not been confirmed, an indication that the user is awaiting a diagnosis;

(6) an indication that, following the consultation, it was determined that the user does not have neoplasia, where applicable;

(7) an indication that the administration of systemic treatment (chemotherapy, targeted therapy or immunotherapy) was deemed appropriate following the consultation or that the treatment plan has not yet been determined;

(8) regarding the systemic treatment administered or determined following the consultation:

(a) the date on which it is administered for the first time;

(b) an indication of whether it is administered orally or intravenously;

(c) in the case of intravenous systemic treatment:

i. an indication that the treatment is administered in an institution other than the institution where the consultation was carried out, where applicable;

ii. an indication that the treatment is administered simultaneously with radiotherapy, where applicable;

(9) if the administration of systemic treatment was not deemed appropriate following the consultation, an indication of whether another treatment will be administered or that only active follow-up will be maintained;

(10) for each period of the user's unavailability:

(a) the dates on which the user's unavailability begins and ends;

(b) an indication of whether the unavailability is due to personal or medical reasons;

(11) the explanations of the institution regarding any delays incurred and any period of unavailability reported.

4. Every transmission of the information required under sections 2 and 3 must be accompanied by the following:

(1) the year, financial period and week number concerned;

(2) the name and permit number of the institution concerned;

(3) the name and number, on the institution's permit, of the facility concerned.

O.C. 759-2019, s. 5; O.C. 317-2022, s. 5.

SCHEDULE V.2

(s. 5.1.2)

1. The institution referred to in section 5.1.2 must provide the following information in respect of any user to whom it provided a first dialysis treatment:

(1) concerning the user:

(a) sex;

(b) ethnic origin;

(c) the postal code of the user's residence;

(d) the name of the municipality where the user's residence is located;

(e) the province where the user's residence is located;

(2) the date of the first consultation of the user with a physician who holds a specialist's certificate in nephrology;

(3) an indication that the user was followed in nephrology before the beginning of the follow-up in renal replacement and the place of the follow-up;

(4) the user's blood levels of albumin, serum bicarbonate, creatinine, calcium, hemoglobin, parathormone, phosphate and urea before the user's first treatment;

(5) the user's height at the time of the first treatment;

(6) the user's weight in the month of the first treatment;

(7) an indication that the user suffered a bilateral leg amputation, where applicable;

(8) the user's diagnosis of renal disease;

(9) an indication of the user's risk factors for renal disease and the nature of those factors, where applicable;

(10) regarding the first administered renal replacement treatment:

(a) date;

(b) type;

(c) the place where it was administered;

(d) the level of help or care needed during its administration;

(e) the type of access used;

(f) an indication whether or not it was the long-term intended treatment for the user;

(g) the reason for which the long-term intended treatment for the user could not be administered, where applicable;

(11) concerning the long-term intended treatment for the user:

(a) type;

(b) the place where it should be administered;

(c) the level of help or care needed during its administration.

2. The institution referred to in section 5.1.2 must provide the following information in respect of a user for whom it performs the monitoring of dialysis treatments:

(1) concerning a user receiving any type of dialysis:

(a) the postal code of the user's residence;

(b) regarding the user's blood levels of albumin, calcium, creatinine, ferritin, hemoglobin, glycated hemoglobin, parathormone, phosphate, transferrin and urea:

i. the laboratory results;

ii. the date on which each test was conducted;

iii. an indication of the tests that were not conducted, where applicable;

(c) an indication that the user is registered on the waiting list for renal transplant, that the user is not waiting for renal transplant or that an evaluation is underway for the user to be registered on the waiting list;

(d) if the user is under 18 years of age, the user's height and the date of the measurement;

(2) concerning a user receiving peritoneal dialysis treatments:

(a) the user's weight, the date on which the user was weighed and an indication that the user was weighed when the user was empty or full of fluid;

(b) the weekly creatinine clearance and the date of its verification, where applicable;

(c) the weekly measure of urea clearance (Kt/V) and the date of its verification, where applicable;

(d) an indication that the weekly creatinine clearance or that the weekly measure of urea clearance is not carried out or is not done systematically, where applicable;

(3) concerning a user receiving hemodialysis treatments:

(a) the type of access used on the day on which the laboratory results were obtained;

(b) the user's weight before and after the treatment, and the date of weighing;

(c) the weekly frequency of treatments and their duration.

3. The institution referred to in section 5.1.2 must provide the following information in respect of a user to whom it provides renal replacement services and that it transfers to a facility or whose treatment has changed or stopped:

(1) concerning the last dialysis treatment administered to a user:

(a) type;

(b) the place where it was administered;

(c) the level of help or care needed during its administration;

(d) the number, on the institution's permit, of the facility where it was administered;

(2) concerning any transfer of a user to another facility:

(a) date;

(b) cause;

(c) the number, on the institution's permit, of the facility of destination;

(3) concerning any change of treatment:

(a) date;

(b) cause;

(c) regarding the new treatment administered:

i. type;

ii. the place where it was administered;

iii. the level of help or care needed during its administration;

(d) the number, on the institution's permit, of the facility where it was administered;

(4) if a user received a transplant, the transplanted organ;

(5) in the case of treatment interruption, the date and cause of that interruption;

(6) the date and cause of death of the user, where applicable.

4. In addition, upon any provision of information, the institution referred to in section 5.1.2 must provide the following information:

(1) concerning the identity of the user:

(a) name;

(b) date of birth;

(c) health insurance number;

(d) the province or territory responsible for the health care insurance plan insuring the user;

(2) the number, on the institution's permit, of the transmitting facility.

O.C. 759-2019, s. 5; O.C. 317-2022, s. 6.

SCHEDULE V.3

(s. 5.1.3)

1. An institution referred to in section 5.1.3 of the Regulation must provide the following information:

(1) the sequence number assigned to the test by the laboratory;

(2) the date on which the sample was taken;

(3) the date on which the sample was received at the laboratory;

(4) an indication that the test must be conducted again and the reason therefor, where applicable;

(5) concerning any immunochemical fecal occult blood test, the numerical result of the test and an indication of whether it was deemed positive, negative or invalid;

(6) concerning any human papillomavirus test:

(a) the anatomical region where the sample was taken;

(b) the result of the test and an indication of whether it was deemed positive, negative or invalid;

(7) the date of verification of the result of the test;

(8) the name and number, on the institution's permit, of the facility, or the name of the private health facility, where the person who prescribed the test was practising at the time of prescription;

(9) the name and permit number of the institution that provided services to the user;

(10) the name and number, on the institution's permit, of the facility that provided services to the user.

O.C. 317-2022, s. 7.

SCHEDULE VI

1. An institution referred to in section 5.2:

(1) concerning any user:

(a) the user's sex and year of birth;

(b) an indication that the user is a Native and, if applicable, whether the user is a beneficiary under the Agreement concerning James Bay and Northern Québec or under the Northeastern Québec Agreement or whether the user lives on an Indian reserve;

(c) the code corresponding to the natural person who has de facto custody of the user;

(d) the sequence number assigned to the user upon receipt of a request for services concerning the user;

(e) the language used during the intervention and that used in daily activities;

(f) the sequence number assigned to the user's home address and the first 3 characters of the user's postal code;

(g) the code of the regional county municipality where the user's residence is located and, if the residence is located in another province, territory or country, the code of that province, territory or country;

(h) the dates on which the association, by the institution, of the home address with the user begins and ends;

(i) the code of the territory of the local community service centre that serves the area where the user's residence is located;

(j) if the user receives services required by the user's situation under the Youth Criminal Justice Act (S.C. 2002, c. 1):

i. the user's country of birth and year of arrival in Québec if the user was born outside Canada; and

ii. an indication that the user has reoffended;

(k) the user's overall deprivation;

(l) the user's material deprivation; and

(m) the user's social deprivation;

(2) concerning any request for services:

(a) the age of the user at the time of the request;

(b) the type of services concerned by the request;

(c) the means of communication used to file the request with the institution;

(d) an indication that the request was received during regular working hours;

(e) the date of receipt of the request;

(f) the date as of which the user ceases to receive the services related to the request; and

(g) the sequence number assigned to the request;

(3) concerning specifically any request for services required by the situation of a child under the Youth Protection Act (chapter P-34.1), and any related request for services:

(a) an indication that no other service is already being provided to the child by the institution as part of the operation of any of the centres referred to in section 5.2, where applicable;

(b) the identification of other services received from the institution by the child as part of the operation of any of the centres referred to in section 5.2, where applicable; and

(c) the identification of the service that is most important for the child, when more than one service is provided as part of the operation of any of the centres referred to in section 5.2;

(4) concerning specifically any request for services required by an adolescent under the Youth Criminal Justice Act:

(a) the code of the territorial division where the offence concerned by the request was committed;

(b) the code of the institution to which the adolescent is referred, if applicable;

(c) the sequence number assigned to the most serious offence associated with the request for services; and

(d) the reason for which the service request file was closed;

(5) concerning any request for information or consultation made to the institution:

(a) an indication of whether it is a request for information or a request for consultation;

(b) an indication that the person concerned by the request is a Native and, if applicable, whether the person is a beneficiary under the Agreement concerning James Bay and Northern Québec or under the Northeastern Québec Agreement or whether the person lives on an Indian reserve;

(c) the means of communication used to file the request with the institution;

(d) an indication that the request was received during regular working hours;

(e) the date of receipt of the request;

(f) the date on which the request ends;

(g) the age group of the person concerned by the request;

(h) the sequence number assigned to the request;

(i) the class of the person who made the request, based on the person's relationship to the person concerned by the request or the person's occupation; and

(j) the nature of the response to the request;

(6) concerning any service rendered:

(a) the institution to which the user is referred, where applicable;

(b) the date on which the service is first assigned;

(c) the date of the provider's first significant contact with the user, the user's family or an interlocutor from the living environment for the purpose of initiating the service;

(d) the dates on which the service begins and ends;

(e) the age of the user when the service is provided;

(f) the sequence number assigned to the service;

(g) the date on which the service is first assigned to a provider;

(h) an indication of whether the service is assigned to a provider from the institution or to a third person;

(i) the type of responsibility assumed by the provider in regard to the service;

(j) the date on which a clinical activity is performed by the provider;

(k) the type of clinical activity performed as part of the service, the duration of the activity and an indication of whether the child, the child's mother, the child's father or any other person took part in the activity, if applicable;

(l) the sequence number assigned to the clinical activity; and

(m) the action to be taken following the end of the service;

(7) concerning specifically any service rendered under the Youth Criminal Justice Act and the information gathered at that time:

(a) regarding any situation of neglect, sexual abuse or physical abuse of a child within the meaning of subparagraph *b*, *d* or *e* of the second paragraph of section 38 of the Youth Protection Act, or any disclosure of that situation:

i. the age group of the person presumed to have neglected the child or committed the abuse and the person's sex and assigned sequence number;

ii. an indication of whether the person was living with the child at the time of the situation of neglect or abuse and the person's relationship to the child at that time;

iii. the date on which the director of youth protection decided whether or not to disclose the situation and, where applicable, the date on which the director disclosed it;

iv. an indication of whether the child or one of the child's parents agreed to the disclosure;

v. of subparagraphs *b*, *d* and *e* of the second paragraph of section 38 of the Youth Protection Act, the subparagraph that corresponds to the situation that led to the disclosure;

vi. the sequence number assigned to the disclosure made to the police;

vii. an indication that the director of youth protection decided to postpone the disclosure;

viii. an indication that the disclosure was made by a person other than the director of youth protection and whether the disclosure was made following the intervention of the director of youth protection;

ix. an indication of whether the disclosure was deemed inappropriate or unnecessary and the reasons for that decision; and

x. the code of the service during which the recording of information related to the disclosure began and the code of the service during which the disclosure process ended;

(b) regarding any report received by the institution's director of youth protection or any transfer of a child from another territory:

i. the final decision on whether or not to accept the report, the type of reasons that justified the decision and the date on which the decision was made;

ii. the level of priority of the accepted report;

iii. the class of the person who made the report, based on the person's relationship to the child or on the person's occupation;

iv. an indication of whether a provider made the verifications to obtain additional information when the information provided by the person who reported the child's situation does not allow a final decision to be made on whether or not to accept the report;

v. an indication of whether the child and the child's parents received information on the services and resources available in their community or were referred to the institutions, organizations or persons best suited to assist them and, where applicable, the date on which they were referred and the type of institution, organization or person to which they were referred;

vi. the reason why the child and the child's parents were not referred in accordance with subparagraph v;

vii. the code of the institution that filed an application for transfer; and

viii. the last youth protection service completed by the institution that transferred the child, if applicable;

(c) regarding any service for assessing the situation of a child following the acceptance of a report:

i. the final decision on whether the security or development of the child is in danger and the date of the decision; and

ii. the information required under subparagraphs v and vi of subparagraph *b*;

(d) the subparagraph of the second paragraph of section 38 or the subparagraph of section 38.1 of the Youth Protection Act that corresponds to the situation justifying the provision of a service and whether that subparagraph is the primary or secondary reason for providing the service;

(e) regarding any additional assessment:

i. the date of the request for an additional assessment;

ii. the type of additional assessment requested and the sequence number assigned to it;

iii. the code of the applicant;

iv. an indication of whether the additional assessment was performed by the institution or by a third person;

v. an indication of whether the additional assessment concerns the child, the child's mother, the child's father or another person; and

vi. the date of receipt of the report filed following the additional assessment;

(f) regarding any direction service following the assessment of a child:

i. the initial decision proposed by the director of youth protection regarding the implementation of voluntary measures or referral to the tribunal, and the date of the decision;

ii. the date on which the director of youth protection made the final decision to direct the child toward voluntary measures or to refer the child's situation to the tribunal;

iii. the final decision made by the competent authorities regarding the measures to be implemented and the date of the decision;

iv. the date on which a decision is made to proceed with a final intervention before the service ends, the date on which the intervention begins and the duration of the intervention; and

v. the information required under subparagraphs v and vi of subparagraph *b*;

(g) regarding the end of services provided to the child in implementing a measure and the date and type of the final decision made by the competent authorities to end the services;

(h) regarding any measure implemented under the Youth Protection Act:

i. the type of regime, based on whether it involves voluntary measures or court-ordered measures, and the sequence number assigned to it;

ii. the regime's start date, scheduled end date and actual end date;

iii. the type of measures, the start date, scheduled end date, actual end date and assigned sequence number;

iv. an indication of whether the child, the child's mother or the child's father is opposed to the regime or the measures proposed;

v. an indication that the measures must continue until the child reaches full age;

vi. an indication that the emergency measures and the immediate protective measures were taken during regular working hours; and

vii. the code of the reason provided for in the fourth paragraph of section 91.1 of the Youth Protection Act for which the tribunal disregarded the maximum total period of foster care for a child and an indication that an order provided for in the fifth paragraph of that section was issued;

(i) regarding any review of the situation of a child under section 57 of the Youth Protection Act:

i. the type of review; and

ii. the information required under subparagraphs i to iii and v of subparagraph *f*, adapted as required;

(j) regarding any review of the situation of a child under section 57.1 of the Youth Protection Act:

i. the institution to which the request for services was referred, if applicable; and

ii. all of the information required under subparagraph *c*;

(k) regarding any social assessment of a prospective tutor with a view to recommending the tutor to the tribunal:

i. the legal context that led to the request for a social assessment; and

ii. the tribunal's final decision on the recommendation of a person to act as tutor under section 70.1 of the Youth Protection Act and the date of the decision;

(l) regarding any tutorship assumed by the director of youth protection, the final decision on the tutorship and the date of the decision;

(8) concerning specifically any service rendered under the Youth Criminal Justice Act, and the information gathered at that time:

(a) regarding any service, the sequence number assigned to the most serious offence associated with the service;

(b) regarding any assessment-guidance service;

i. the initial decision proposed to the adolescent by the provincial director in regard to measures or services suited to the adolescent's situation;

ii. the date on which the provincial director decided to direct the adolescent toward measures or services;

iii. an indication of whether the provincial director proposed an agreement on extrajudicial sanctions and the adolescent's response to the proposal, where applicable; and

iv. an indication of whether the decision made by the provincial director was based on an individual interview or a group interview with the adolescent;

(c) regarding any alternative justice organization consulted at the time of the assessment-guidance service, the identification of the organization and the sequence number assigned to the consultation at the time of the adolescent's assessment-guidance;

(d) regarding any category of measures, the type of category, the sequence number assigned to it, the start date, scheduled end date and actual end date;

(e) regarding any measure applied in regard to the adolescent:

i. the dates on which the measure begins and ends and the sequence number assigned to it; and

ii. the type of measure and, where applicable, its duration or monetary value;

(f) regarding the follow-up of extrajudicial sanctions:

i. the dates on which the follow-up begins and ends;

ii. the decision on the measures to be applied following an assessment of the implementation of extrajudicial sanctions and the date of the decision; and

iii. the date on which the provincial director is informed of the result of mediation with the victim;

(g) regarding any reassessment of the agreement on extrajudicial sanctions:

i. the circumstances that warrant it; and

ii. the final decision transmitted to the adolescent by the provincial director in regard to appropriate measures or services following the reassessment, and the date of the decision;

(h) regarding any request by the court under section 35 of the Youth Criminal Justice Act, the agency's decision on whether the adolescent needs such services and the date of the decision;

(i) regarding any service rendered following the filing by the police of a request for the detention of an adolescent prior to the adolescent's appearance before the court, the decision by the provincial director to agree or refuse to authorize the detention prior to the adolescent's appearance before the court and the date of the decision;

(j) regarding any offence committed by the adolescent:

i. the offence the adolescent is alleged to have committed and the date on which it was committed;

ii. the decision of the provincial director with regard to the directing of the adolescent;

iii. the final decision of the court, the offence for which the adolescent is found guilty and the date of the judgment; and

iv. the sequence number assigned to the offence;

(k) regarding any victim:

i. the sequence number assigned to the victim; and

ii. the type of harm suffered by the victim;

(l) regarding any consultation of a victim by an alternative justice organization:

i. the date on which the institution transmitted information on the victim to the organization;

ii. an indication that the organization contacted the victim, the action taken afterwards and, if applicable, the victim's response regarding the mediation process;

iii. the date on which the institution received the victim's response from the organization;

iv. the sequence number assigned to the consultation;

v. an indication of whether the victim wants to know the extrajudicial measures taken with respect to the adolescent; and

vi. the victim's reason for refusing to take part in the mediation process;

(m) regarding the filing of a presentence report:

i. the date on which the report was requested by the court and the date on which the request was received by the institution;

ii. the type of report requested by the court;

iii. the means of communication used to file the report and the date on which it was sent to the court; and

iv. the final decision made following the filing of the report and the date of the decision;

(n) regarding any follow-up prior to sentencing and any sentencing follow-up:

i. the final decision concerning follow-up and the date of the decision; and

ii. the final decision concerning sentencing and the date of the decision;

(o) concerning any review of the court judgment as part of sentencing follow-up:

i. the date on which the review was requested;

ii. the code of the applicant;

iii. the code indicating the legal justification for conducting a review;

iv. the professional opinion given by the youth worker in the progress report requested by the court as part of the review;

v. the means of communication used to file the progress report and the date on which the report was sent to the court; and

vi. the final decision of the court on changing or continuing the adolescent's sentence following the review and the date of the decision;

(p) regarding any partnership between the provincial director and an organization as part of the follow-up of extra-judicial sanctions or sentencing follow-up:

i. the date on which the institution made the partnership request to the partner organization;

ii. the sequence number assigned to the partnership; and

iii. the code of the partner organization;

(q) concerning any information laid regarding a breach of probation conditions, the date on which the information was laid and the sequence number assigned to the information;

(r) regarding any filing of an expert report:

i. the date on which the report was requested by the court and the date on which the request was received by the institution;

ii. the type of report requested by the court;

iii. an indication of whether the report was prepared by the institution or by a third person;

iv. the date on which the institution received the report and the date on which the report was sent to the court; and

v. the final decision made following the filing of the report and the date of the decision;

(s) regarding any absence of an adolescent who escapes or is unlawfully at large while committed to custody, the dates on which the absence begins and ends, the type of absence and the sequence number assigned to it; and

(t) regarding any sentence calculation:

i. the sequence number assigned to the sentence;

ii. the dates on which conditional supervision, suspension of conditional supervision, the issue of an arrest warrant, transfer to a correctional facility or a penitentiary, supervision in the community, suspension of supervision in the community, committal to intermittent custody, committal to secure custody or committal to open custody begins and ends, and such dates following the calculation of the sentence;

iii. the date on which the sentence is calculated;

iv. the sequence number assigned to the sentence calculation;

v. the sequence number assigned to the absence or review that leads to the sentence calculation; and

vi. the number of days to be served in custody and the number of days to be served in custody in the community, as well as the number of such days after the sentence has been calculated.

O.C. 719-2012, s. 2; O.C. 859-2018, s. 5.

SCHEDULE VI.1

(s. 5.2.1)

1. The institution referred to in section 5.2.1 must provide the following information:

(1) concerning the user:

(a) the name of the user's mother;

(b) the name of the user's father;

(c) the reason why the user's health insurance number cannot be provided, if applicable;

(d) the date of the user's first admission to or registration in an institution to obtain specialized and superspecialized services in intellectual impairment, autism spectrum disorders or physical impairment;

(e) the type of living environment where the user is residing;

(f) the date of the user's arrival in the living environment and, if a change occurs, the date of the user's departure;

(g) the date of the user's death, where applicable;

(2) concerning any control measure applied to a user:

(a) the date and time on which the application of the control measure begins and ends;

(b) an indication that a user or a representative agreed to the application of the control measure;

(3) concerning the billing of services rendered to a user:

(a) the organization or type of person assuming the cost of services rendered to the user;

(b) the date of the event for which services are billed, where applicable;

(4) concerning any request for services:

(a) the date of its receipt;

(b) the date of its registration;

(c) the type of person or organization having referred the user to the institution;

(d) the state of its realization;

(e) the type of clientele to which the user belongs;

(f) the diagnosis of impairment for which a request for services was made;

(g) the date on which all the information required for the purposes of examination of the request was obtained;

(h) the decision rendered after examination of the request and the date on which it was rendered;

(i) the priority code assigned to the request;

(j) the date on which any treatment suspension of the request for services begins and ends, and the reason for that suspension;

(k) the date on which the request is closed;

(5) concerning the assignment of the request for services:

(a) the centre or sub-centre of activities to which the request is assigned;

(b) the disciplines or clinical functions to which the request is assigned;

(c) the types of resources to which the request is assigned;

(d) the service settings to which the request is assigned;

(e) the administrative units to which the request is assigned;

(f) the date on which any assignment begins and ends;

(g) the reason for the cessation of any assignment;

(h) the date on which any assignment suspension begins and ends, and the reasons for that suspension;

(6) concerning the planning of services to render to a user:

(a) regarding the individualized service plan for a user:

i. the date of the meeting for its development;

ii. whether or not the user participated in its development;

iii. the date on which its application ends;

(b) concerning the intervention plan for a user:

i. the date of the meeting for its development;

ii. whether or not the user participated in its development;

iii. the date of its revision;

iv. the date on which its application ends;

(7) concerning the services rendered to a user:

(a) the date of each service provided to a user;

(b) the type of intervention carried out by any provider;

(c) the total duration of services provided to a user;

(d) the date on which any suspension of the provision of services begins and ends, and the reason for that suspension;

(e) the number of times a user attends an activity organized by the institution;

(f) the dates of admission to an institution, the dates on which a user obtained a leave from the institution and the total number of days of a user's lodging, where applicable;

(g) the type of external resource or the mission of the centre operated by an institution to which a user was referred, and the date and ground for that reference;

(8) concerning any provision of information:

(a) the name and the permit number of the institution that provides services to a user;

(b) the number, on the institution's permit, of the facility where services are provided to a user;

(c) the code of the health region from which the information originates;

(d) the date of transmission;

(e) the sequential number assigned to the transmission;

(f) the date on which the transmission period concerned begins and ends.

O.C. 759-2019, s. 6.

SCHEDULE VI.2

(s. 5.2.2)

1. An institution referred to in section 5.2.2 of the Regulation must provide the following information in respect of any type of user:

(1) concerning each request for services:

(a) sequence number;

(b) date of receipt;

(c) origin;

(d) object;

(e) the centre or sub-centre of activities concerned;

(f) the decision rendered after examination of the request and the date of the decision;

(g) an indication that it is a request from an individual or a group;

(h) the priority code assigned to the request;

(2) indication of the type of user;

(3) concerning each sporadic intervention or activity:

(a) sequence number;

(b) the centre or sub-centre of activities concerned;

(c) date;

(d) type;

(e) the reasons therefor;

(f) any act performed by the provider;

(g) follow-up;

(h) the master program to which it is related;

(i) the intervention program to which it is related;

(j) mode;

(k) the place of the intervention or activity;

(l) in the case of an intervention, the duration;

(m) the language used during the intervention or activity;

(n) the provider's class of employment and link with the institution;

(o) the number of providers participating in the intervention or activity;

(p) if the intervention or activity is performed in a school environment, the education level;

(q) if the intervention or activity is intended for a group user, the number of participants;

(4) the category and target population of the group user.

2. In addition to the information required under section 1, an institution referred to in section 5.2.2 of the Regulation must provide the following information in respect of any individual user:

(1) concerning the user:

(a) the reason for which the user's health insurance number cannot be provided, where applicable;

(b) the province or territory responsible for the health care insurance plan insuring the user;

(c) the date on which the user's file was opened;

(d) the code of the territory of the local community service centre where the user's residence is located;

(e) the user's overall deprivation;

(f) the user's material deprivation;

(g) the user's social deprivation;

(2) concerning each episode of service rendered to the user:

(a) the sequence number;

(b) the dates on which the service begins and ends;

(c) the sequence number of its assignment to a centre or sub-centre of activities;

(d) the centre or sub-centre of activities covered by the assignment;

(e) the dates on which the assignment begins and ends;

(f) the priority code assigned to the assignment;

(g) the sequence number associated to each period of the user's unavailability, where applicable;

(h) the dates on which the user's unavailability begins and ends, where applicable;

(i) the date on which services will be required for the user at a later date;

(j) the reason for interrupting the service episode;

(3) concerning each addiction profile drawn up for the user:

(a) the sequence number;

(b) an indication that the assessment was conducted directly by the institution operating the rehabilitation centre for persons with an addiction or by an external resource;

(c) the date of the assessment and, if the assessment could not be conducted in a single session, the date on which the assessment was continued;

(d) the types of disorders related to psychoactive substance use, gambling or problematic Internet use observed in the user;

(e) the level of services required by the user, as determined in the assessment;

(f) the conditions observed in the user that require particular follow-up;

(g) an indication of whether the user lives with a partner with or without children, is a single parent, lives alone, lives with a relative, or lives with a non-relative;

(h) the type of the user's occupation;

(4) concerning each stay of the user in a facility maintained by an institution operating a rehabilitation centre belonging to the class of rehabilitation centres for persons with an addiction:

(a) the sequence number;

(b) the reason for the user's admission;

(c) the date and time of the user's admission;

(d) the date and time on which the user's lodging ends;

(e) the reason for ending the lodging;

(f) the dates on which each occupied bed in the institution began and ceased to be occupied, and the duration of each occupation;

(g) the total duration of the user's lodging in the institution.

3. Every transmission of the information required under sections 1 and 2 must be accompanied by the following:

(1) the code of the health region from which the information originates;

(2) the permit number of the institution providing the information;

(3) the date of transmission;

(4) the number assigned to the transmission;

(5) the dates on which the period concerned begins and ends.

O.C. 317-2022, s. 8.

SCHEDULE VII

(s. 5.3)

1. The institution referred to in section 5.3 provides the following information:

(1) concerning the user:

(a) the name of the user's mother;

(b) the reason for which the user's health insurance number cannot be provided, where applicable;

(c) the date of death, where applicable;

(d) the address of the user's permanent place of residence;

(e) the address and code of the municipality of the place where the user is staying, where applicable;

(2) concerning any identification of the user's loss of autonomy using the tool Prisma-7:

(a) the care and service program and the centre or sub-centre of activities to which the identification is associated;

(b) the dates of beginning and end of the association of the identification with the centre or sub-centre of activities;

(c) the dates of beginning and end of the user's participation in the care and service program;

(d) the sequential number assigned to the identification;

(e) the date on which identification began and the date on which it is completed;

(f) the result of the identification;

(g) the permit number of the institution where the identification was conducted;

(h) the number, on the institution's permit, of the facility where the identification was conducted;

(3) concerning any assessment of the user's loss of autonomy using the multi-clientele assessment tool (OEMC) or the functional autonomy measurement system (SMAF) exclusively;

(a) the assessment model used;

(b) the care and service program and the centre or sub-centre of activities to which the assessment is associated;

(c) the dates of beginning and end of the association of the assessment with the centre or sub-centre of activities;

(d) the dates of beginning and end of the user's participation in the care and service program;

(e) the sequential number assigned to the assessment;

(f) the date on which assessment began and the date on which it is completed;

(g) upon any provision of information, the history of the statements of realization of the assessment and the dates on which those statements of realization have changed;

(h) the results of the computation of the SMAF and social SMAF;

(i) the results of the computation of incapacity and handicap for each element of the SMAF and social SMAF;

(j) the type of resource-person who renders services to the user with respect to each element of the SMAF and an indication of the resource's stability for each of those elements;

(k) the Iso-SMAF profile;

(l) the Euclidean distance;

(m) the employment title of the provider who conducted the assessment;

(n) the permit number of the institution that provides assessment services to the user;

(o) the number, on the institution's permit, of the facility that provides assessment services to the user;

(p) the type of resource or living environment where the assessment was conducted;

(q) the name and code of the local services network entered in the file of the user concerned by the assessment;

(r) the name and code of the local services network where the residence of the user concerned by the assessment is located;

(s) the type of living environment where the user concerned by the assessment is residing and, in the case of a facility maintained by an institution, a private seniors' residence or another lodging resource, the name of that facility, residence or resource;

(t) an indication that a case management worker participated in the assessment, where applicable;

(u) for each element of the SMAF that was assessed:

i. the items and technical aids used by the user to compensate for incapacity, where applicable;

ii. an indication of whether the human resources available to compensate for the user's incapacity meet the user's needs, do not meet them, or meet them in part and, in the latter case, of whether that shortcoming is due to the quantity of services obtained, the quality of those services, or both;

(3.1) concerning a user who underwent an assessment of his or her loss of autonomy using the OEMC or the SMAF:

(a) the weekly frequency at which the user takes care of his partial or complete hygiene or at which it is provided to the user, and an indication of the mode of hygiene used;

(b) an indication of whether the user is able to get around inside the living environment using a wheelchair;

(c) an indication of whether the user is able to get around using a wheelchair, a 3-wheel scooter or a 4-wheel scooter within 20 m of the living environment;

(d) an indication of whether the user uses stairs;

(3.2) concerning a user who underwent an assessment of his or her loss of autonomy using the OEMC:

(a) if the user is 65 years of age or over, an indication of whether examination of the file revealed a nutritional risk, and the level of risk identified;

(b) an indication of whether static and dynamic synthesis of the file using the OEMC revealed signs of the following risks:

i. if the user is under 65 years of age, the user's nutritional risk;

ii. the user's risk of falling;

iii. the risk of exhaustion of the user's informal caregiver;

iv. the user's risk of wound;

v. the user's risk of suicide;

vi. the risk of maltreatment toward the user and, when specified, the types of risks of maltreatment (physical, sexual, material or financial and psychological);

vii. the risk of neglect toward the user;

viii. the risk of the user's rights being violated;

ix. the user's risk of fragility;

(c) regarding the user's state of health:

i. the user's body mass index;

ii. the weight fluctuations observed in the user during the year preceding the assessment;

iii. an indication of whether the user has a medical history;

iv. an indication of whether the user was hospitalized during the year preceding the assessment and the reason for that hospitalization, where applicable;

v. an indication of whether the user fell during the year preceding the assessment and the number of falls, where applicable;

vi. an indication of whether the user expresses a fear of falling, or an indication that the user is unable to answer that question;

vii. the symptoms experienced by the user with regard to the user's sensory, genitourinary, digestive and motor functions, the condition of the user's skin, and the user's mood or anxiety disorders, suicidal ideation, agitation or disruptive behaviours;

viii. an indication of whether the user has a mental health problem and, if so, of whether that problem is taken in charge;

ix. an indication of whether the user has experienced trauma and, if so, the type of trauma;

x. the reason why the user has difficulty taking medication, where applicable;

xi. the type of side effects experienced by the user after taking his or her medication, where applicable;

xii. the extent to which the user felt weak during the 4 weeks preceding the assessment, or an indication that the user is unable to answer that question;

xiii. an indication of whether the user is followed by a family physician;

xiv. an indication of whether the user is followed by a medical specialist;

xv. an indication of whether the user is followed by a health or social services professional who is not a physician;

(d) regarding the user's lifestyle:

i. the user's appetite level;

ii. an indication of whether the user feeds orally, enterally or parenterally, or through a combination of those methods;

iii. an indication of whether the user eats the following foods for breakfast:

I) fruits or fruit juice;

II) eggs, cheese or peanut butter;

III) bread or cereal;

IV) milk;

iv. the nature of the user's feeding problems, where applicable;

v. the user's type of dentition;

vi. the weekly frequency at which the user consumes alcohol;

vii. the weekly frequency at which the user walks for at least 10 minutes;

viii. the weekly frequency at which the user plays sports for at least 10 continuous minutes;

ix. the weekly frequency at which the user engages in moderate activity;

x. an indication of whether the user has ceased or significantly reduced a social activity he or she engaged in during the year preceding the assessment and the reasons therefor, where applicable;

(e) regarding the user's psychosocial state:

i. an indication of any previous event experienced by the user that is likely to significantly impact his or her lifestyle and the date of each event identified, where applicable;

ii. an indication of whether the user is surrounded by a family or social network;

iii. an indication of whether the user is assisted by an informal caregiver;

iv. regarding each informal caregiver of the user, where applicable:

I) an indication of whether he or she is the main informal caregiver or another type of informal caregiver;

II) an indication that he or she is 75 years of age or over, where applicable;

III) the date on which he or she began providing services to the user;

IV) an indication of whether he or she cohabits with the user;

V) an indication of whether his or her income is sufficient to meet his or her needs;

VI) his or her state of health;

VII) the nature of his or her relationship with the user;

VIII) his or her employment status;

IX) the nature of the problems with regard to his or her role in the user's life, as stated by the user or observed by the provider, where applicable;

X) the weekly frequency at which he or she is involved with the user;

XI) an indication of whether he or she is satisfied with his or her situation;

XII) an indication of whether the user has agreed to have the institution communicate with the informal caregiver concerned;

v. the nature of the user's family dynamics;

vi. the type of contact between the user and his or her social or family network, and the frequency of that contact;

vii. the state of the relationship between the user and his or her social or family network;

viii. the nature of the social support that the user receives from his or her social or family network;

ix. the types of maltreatment of which the user seems to be a victim, where applicable;

x. the emotional state expressed by the user;

xi. the user's perception of his or her general situation;

xii. the nature of the means used or not used by the user in order to get his or her situation under control, or an indication that the user is unable to answer that question;

xiii. the nature of the user's problems with regard to his or her intimate and emotional life, where applicable;

xiv. the nature of the user's problems with regard to the practices and obligations related to his or her religion, where applicable;

xv. the type of the user's current occupation;

xvi. the user's civil status;

xvii. an indication of whether the user lives with a partner with or without children, is a single parent, lives alone, lives with a relative, or lives with a non-relative, or an indication that that information is not available;

xviii. the user's number of years of education;

(f) regarding the user's economic situation:

i. an indication of whether the user's income is sufficient to meet his or her needs, or an indication that the user is unable to answer that question;

ii. the nature of the user's problems with regard to finances or payments;

iii. the user's sources of income;

(g) regarding the physical environment in which the user lives:

i. the nature of the elements whose absence or presence in the user's living environment is likely to cause a risk of falling, where applicable;

ii. the nature of the user's problems with regard to accessibility inside his or her living environment;

iii. an indication of whether the user avoids going up stairs or carrying small loads;

(3.3) an indication of whether an assessment of the user's social functioning was conducted using the OEMC and, if so, the date of that assessment;

(4) concerning any individualized service plan or intervention plan established for the user and any new version of those plans:

(a) the type of plan;

(b) the care and service program and the centre or sub-centre of activities to which the plan is associated;

(c) the dates of beginning and end of the association of the plan with the centre or sub-centre of activities;

(d) the date of beginning and end of the user's participation in the care and service program;

(e) the sequential number assigned to the plan;

(f) the version number;

(g) the goal of the plan;

(h) the date of creation of the plan version and the date on which it was completed;

(i) the date on which the plan was developed;

(j) upon any provision of information, the history of the statements of conduct of the plan and the dates on which those statements of conduct have changed;

(k) the means to be used and the interventions to be performed, identified on the plan, and the category to which they are related, their frequency, the day fixed for their implementation, their dates of beginning and end, the time allocated to them, the place where they are implemented or performed, the type of provider assigned to them, the centre and sub-centre of activities to which they are associated at the time of planning, the identity of their provider, and the link between the provider and the user, where applicable;

(l) the date of any revision of the plan;

(l.1) the date of any improvement of the plan;

(m) the degree of achievement of the objectives per type of act;

(n) the degree of acceptance of the plan by the user;

(o) the employment title of the provider in charge of the plan;

(p) a mention that the case was assigned to a case manager or a pivotal provider and the dates of beginning and end of the assignment of the case to any case manager or pivotal provider;

(q) the permit number of the institution where the plan was carried out;

(r) the number, on the institution's permit, of the facility where the plan was carried out;

(s) an indication that a case management worker participated in the development of the plan, where applicable;

(5) concerning any transmission of information to the Minister:

(a) the permit number of the institution from which the data is provided;

(b) the code of the health region from which the information originates;

(c) the date of transmission;

(d) the number assigned to the transmission;

(e) the dates on which the period concerned begins and ends;

(6) concerning the therapeutic nursing plan established for the user:

(a) the date of preparation of the plan;

(b) the sector of activities to which the user is associated at the time the plan is established;

(c) the date of any modification of the plan;

(d) respecting any statement on the general state of the user entered in the plan by a nurse:

i. a description of the statement;

ii. specifications associated to it, where applicable;

iii. the date and time the statement was established;

iv. the title and duties of the nurse who established the statement and the service program to which the nurse is assigned;

v. the sector of activities to which the user is associated at the time the statement is established;

vi. the type of professionals or the service identified by the nurse to remedy the problem;

vii. the title and duties of the nurse who established the plan if it is not the person referred to in subparagraph *iv*;

viii. its state of realization and the date of any modification to that state of realization;

ix. the title and duties of the nurse who modified the state of realization, where applicable, and the service program to which the nurse is assigned;

x. the category, element and theme associated with it;

xi. the reason for correcting the statement, where applicable;

(e) respecting any directive associated with the statement:

i. a description of the directive;

ii. specifications associated with it, where applicable;

iii. the date and time the directive is established;

iv. the title, duties and service program to which the nurse who established it is assigned;

v. the state of its realization and the date of any modification to that state of realization;

vi. the title and duties of the nurse who modified the state of realization, where applicable, and the service program to which the nurse is assigned;

vii. the category, element and theme associated with it;

viii. the reason for correcting the directive, where applicable;

(f) the name and number, on the institution's permit, of the first facility where the user was received.

O.C. 753-2014, s. 4; O.C. 859-2018, s. 6; O.C. 317-2022, s. 9.

UPDATES
O.C. 103-2009, 2009 G.O. 2, 194
O.C. 732-2011, 2011 G.O. 2, 1622
O.C. 719-2012, 2012 G.O. 2, 2334
O.C. 753-2014, 2014 G.O. 2, 1810
O.C. 859-2018, 2018 G.O. 2, 2770
O.C. 759-2019, 2019 G.O. 2, 1640
O.C. 317-2022, 2022 G.O. 2, 962
S.Q. 2020, c. 20, s. 44