WAC 246-830-565 Recordkeeping. (1) A massage therapist providing professional services to a client or patient must document services provided. Documentation should be appropriate to the venue, the type and complexity of those services and, when applicable, in sufficient detail to support and enable anticipated continuity of care. The documentation must include:

(a) Client or patient name and contact information or name and contact information of a parent or guardian if a client or patient is under eighteen years of age;

(b) Age of client or patient;

(c) Health history sufficient to ascertain if there are cautions or contraindications to safe application of massage therapy, and an update of the current health status at each session;

(d) Date massage therapy is provided and the duration of treatment;

(e) The types of techniques and modalities applied;

(f) The location or areas of the body that received massage therapy;

(g) Written informed consent to treat. A written consent is considered valid for one year unless revoked;

(h) If breast massage is performed, an additional written consent to treat per WAC 246-830-555, and documentation of a therapeutic rationale;

(i) If breast massage that includes the nipples and areolae is involved, documentation of the prescription or referral per WAC 246-830-555 (3)(a), or an additional written consent to treat per WAC 246-830-555 (3)(b);

(j) If performing massage of the gluteal cleft or perineum, an additional written and verbal informed consent to treat is required to detail that the client or patient has a clear understanding of the therapeutic rationale, treatment plan, and areas to be massaged for that region per WAC 246-830-557(4);

(k) Documentation of any written consent or any modification in coverage and draping as required by WAC 246-830-560; and

(l) For massage therapy where the focus is on treating a health condition, the following additional information is required:

(i) Symptoms, for example, pain, loss of function, and muscle stiffness;

(ii) Evaluation and findings, for example, movement, posture, palpation assessment and findings;

(iii) Outcome measures, for example, improvement in symptoms, movement, posture, palpation, and function; and

(iv) Treatment plan for future sessions.

(2) Client or patient records must be legible, permanent, and recorded within twenty-four hours of treatment. Documentation that is not recorded on the date of service must designate both the date of service and the date of the chart note entry. Corrections or additions to the client's or patient's records must be corrected by a single line drawn through the text and initialed so the original entry remains legible. In the case of computer-organized documentation, unintended entries may be identified and corrected, but must not be deleted from the record once the record is signed and completed or locked. Errors in spelling and grammar may be corrected and deleted.

(3) Correspondence relating to any referrals by other health care providers concerning the diagnosis, evaluation or treatment of the client or patient must be retained in the client or patient record.

(4) Client or patient records should clearly identify the massage therapist who is the provider of services by name and signature or electronic signature and date of service.

[Statutory Authority: RCW 18.108.085 (1)(a), 18.108.025 (1)(a), chapter 18.108 RCW and 2020 c 76. WSR 21-02-012, § 246-830-565, filed 12/24/20, effective 9/1/21. Statutory Authority: RCW 18.108.025 (1)(a), 18.108.085 (1)(a), 43.70.041 and chapter 18.108 RCW. WSR 17-14-062, § 246-830-565, filed 6/29/17, effective 7/30/17.]