



Consultation Notes

Patient health information shall be recorded in detail in health records ensuring that another GP or clinical staff member can read and understand the terminology and abbreviations used and manage and continue the care of patients. Information relating to patients should be managed and recorded in a way that makes the information readily accessible.

RACGP Standards

1.7.3 *Each of our patient health records contains sufficient information about each consultation to allow another doctor to carry on the management of the patient.*

Assessment methods

- Document review of patient health records

Surveyors will review a number of patient health records to ensure they meet the requirements as listed in 1.7.3A and B, where applicable.

Meeting the standards

Information should be entered into the patient health record at the time of each consultation including after hours, home visits, and those via the telephone or as soon as information relating to the patient becomes available. This information should include the date of consultation, patient reason, relevant clinical findings, diagnosis, recommended management plan, any prescribed medicine, relevant preventative care, documentation of any referral to other health care providers or health services, any special advice or other instructions and identification of who conducted the consultation.

Any follow up information should also be entered into the patient health record.

Best Practice

- Information is legible and comprehensive.
- Information contains details of all patient contact including telephone calls.
- Information is entered into the patient health record at the time of each consultation or as soon as information relating to the patient becomes available e.g. results, to allow another GP to carry on the management of the patient if required.
- Health summaries are regularly updated as a further method of continually ensuring the comprehensive nature of the clinical information