**General Practitioner: Date:**

|  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Requirement | Health Record 1 | Health Record 2 | Health Record 3 | Health Record 4 | Health Record 5 | Health Record 6 | Health Record 7 | Health Record 8 | Health Record 9 | Health Record 10 |
| Consultation Notes |
| Where relevant, document the following in consultation notes: |
| When team members have attempted to contact (e.g. left phone message)/contacted the patient/a patient contacts the practice; the reason for the contact, and the advice and information the patient was given. |  |  |  |  |  |  |  |  |  |  |
| The treatment options and associated risks and side effects that you have explained and discussed with the patient. |  |  |  |  |  |  |  |  |  |  |
| The patient’s refusal to obtain or follow any clinician’s advice. |  |  |  |  |  |  |  |  |  |  |
| Details of any translation services used for that patient. |  |  |  |  |  |  |  |  |  |  |
| Details of any communication services used (e.g. National Relay Service). |  |  |  |  |  |  |  |  |  |  |
| Any refusals to recommended treatment and the conversation undertaken in response to refusal. |  |  |  |  |  |  |  |  |  |  |
| Patient’s decisions to seek another clinical opinion. |  |  |  |  |  |  |  |  |  |  |
| Patient’s consent to the presence of a third party arranged by the practice, who that thrid party is and what purpose they serve (chaperone, interpreter etc.) |  |  |  |  |  |  |  |  |  |  |
| Patient’s consent for their information to be used in research activities. |  |  |  |  |  |  |  |  |  |  |
| Discussions or activities relating to preventive health. |  |  |  |  |  |  |  |  |  |  |
| Discussions of medicines and treatments. |  |  |  |  |  |  |  |  |  |  |
| Discussions regarding patient’s roles in their own treatment. |  |  |  |  |  |  |  |  |  |  |
| Medicines reviews including information given to the patient about the purpose, importance, benefits and risks of their medicines. |  |  |  |  |  |  |  |  |  |  |
| When team members have made visits to homes and other settings. |  |  |  |  |  |  |  |  |  |  |
| Details of after-hours care the patient has received (eg entries made by the practice team, treatment reports from the health service that provided the care). |  |  |  |  |  |  |  |  |  |  |
| Each attempt to contact and recall patients about clinically significant results. |  |  |  |  |  |  |  |  |  |  |
| What follow-up has occurred and what treatment, if any, was required. |  |  |  |  |  |  |  |  |  |  |
| Conversations about test results. |  |  |  |  |  |  |  |  |  |  |
| Conversations about matters from previous consultations being followed up. |  |  |  |  |  |  |  |  |  |  |
| Details of the patient’s decision to cease receiving care, and the action taken. |  |  |  |  |  |  |  |  |  |  |
| Details of the practitioner’s decision to cease providing care, and the action taken. |  |  |  |  |  |  |  |  |  |  |
| Ensure consultation notes include all mandatory elements, including: |
| * Date of consultation
 |  |  |  |  |  |  |  |  |  |  |
| * Who conducted the consultation (eg. Initials in notes or audit trail in electronic record)
 |  |  |  |  |  |  |  |  |  |  |
| * Method of communication (eg face to face, email, telephone or other electronic means)
 |  |  |  |  |  |  |  |  |  |  |
| * Patient’s reason for consultation
 |  |  |  |  |  |  |  |  |  |  |
| * Relevant clinical findings
 |  |  |  |  |  |  |  |  |  |  |
| * Diagnosis (if appropriate)
 |  |  |  |  |  |  |  |  |  |  |
| * Recommended management plan (and where appropriate, expected process of review)
 |  |  |  |  |  |  |  |  |  |  |
| * Any medicines prescribed for the patient (including the name, strength, directions for use, dose, frequency, number of repeats and date on which the patient started/ceased/changed the medication)
 |  |  |  |  |  |  |  |  |  |  |
| **Health Summaries** |
| Include for each active patient: |
| * Next of kin
 |  |  |  |  |  |  |  |  |  |  |
| * Identification details
 |  |  |  |  |  |  |  |  |  |  |
| * Allergies
 |  |  |  |  |  |  |  |  |  |  |
| * Contact details
 |  |  |  |  |  |  |  |  |  |  |
| * Demographic
 |  |  |  |  |  |  |  |  |  |  |
| * Emergency contact
 |  |  |  |  |  |  |  |  |  |  |
| * Adverse drug reactions
 |  |  |  |  |  |  |  |  |  |  |
| * Accurate and current medicines list
 |  |  |  |  |  |  |  |  |  |  |
| * Current health problems
 |  |  |  |  |  |  |  |  |  |  |
| * Past health history
 |  |  |  |  |  |  |  |  |  |  |
| * Immunisations
 |  |  |  |  |  |  |  |  |  |  |
| * Family history
 |  |  |  |  |  |  |  |  |  |  |
| * Health risk factors (e.g. smoking, nutrition, alcohol, physical activity)
 |  |  |  |  |  |  |  |  |  |  |
| * Aboriginal and Torres Strait Islander Status
 |  |  |  |  |  |  |  |  |  |  |
| * Social history, including cultural background.
 |  |  |  |  |  |  |  |  |  |  |
| * Sex and gender including variations on sex characteristics where relevant
 |  |  |  |  |  |  |  |  |  |  |
| **Referral Letters** |
| Referral letters must: |
| * include the name and contact details of the referring doctor and the practice
 |  |  |  |  |  |  |  |  |  |  |
| * be legible
 |  |  |  |  |  |  |  |  |  |  |
| * include the patient’s name and date of birth, and at least one other patient identifier
 |  |  |  |  |  |  |  |  |  |  |
| * explain the purpose of the referral
 |  |  |  |  |  |  |  |  |  |  |
| * contain enough information (relevant history, examination findings and current management) so that the other healthcare provider can provide appropriate care to the patient
 |  |  |  |  |  |  |  |  |  |  |
| * not include sensitive patient health information that is not relevant to the referral
 |  |  |  |  |  |  |  |  |  |  |
| * include a list of known allergies, adverse drug reactions and current medicines
 |  |  |  |  |  |  |  |  |  |  |
| * identify the healthcare setting to where the referral is being made (e.g. the specialist practice, outpatient dept etc).
 |  |  |  |  |  |  |  |  |  |  |
| If appropriate, referral letters may also contain: |
| * the name of the healthcare provider to whom the referral is being made, if known
 |  |  |  |  |  |  |  |  |  |  |
| * any relevant information that will help other healthcare providers deliver culturally safe and respectful care (eg language spoken, the need for an interpreter or other communication requirements).
 |  |  |  |  |  |  |  |  |  |  |
| **Other** |
| Keep all records of outgoing correspondence (e.g. referrals, pathology and imaging requests etc.) in the patient's health record.  |  |  |  |  |  |  |  |  |  |  |
| Save all incoming correspondence (e.g. referrals, specialist or allied health correspondence or reports, discharge summaries, test results etc) to patient health record. |  |  |  |  |  |  |  |  |  |  |
| Ensure all documents that are scanned into electronic health records are clear and can be easily read, and make appropriate notes if anything is unclear or illegible |  |  |  |  |  |  |  |  |  |  |
| Ensure all patients have only one dedicated health record within the software that contains all information held about that patient.  |  |  |  |  |  |  |  |  |  |  |
| Use patient management software 'drop down' functions to code patient health information. |  |  |  |  |  |  |  |  |  |  |

**GP Name:**

**Date Audit Performed:**

**Areas Identified as a Strength:**

**Areas Identified for Improvement:**