adviceline injury lawyers

Preparing a medical report

Checklist

As a treating medical practitioner, the TAC, WorkCover or your patient's solicitor may ask you to write a report about your patient and the treatment provided. The following list is intended as a helpful guide.

BE ACCURATE

Detail the patient's history and condition, including: any relevant pre-existing issues, how the injury occurred, symptoms and complaints, diagnosis and prognosis, treatment and frequency of attendances, and your assessment as to the patient's long term need for treatment.

ANSWER THE QUESTIONS

Often you will be asked specific questions for a legal purpose. Answer as best you can, based on your professional opinion or understanding, even if you can only say that something is 'likely' or 'probable' or 'possible'. If you feel you cannot answer a question, then say so, and explain why not.

CONSIDER ANY MATERIAL PROVIDED BUT GIVE YOUR OWN OPINIONS

You might be provided with reports from other practitioners. If you interpret the clinical evidence differently, or if you disagree with those conclusions, say so, and explain why.

DON'T STRAY INTO OTHER AREAS

Issues regarding the cause of an injury often raise complex medical and legal questions. If you are asked to comment on something that is beyond your expertise, don't be drawn in – you can state that the question is outside your specialisation.

IF YOU FEEL YOU CANNOT SUPPORT YOUR PATIENT – SAY SO FIRST

If for whatever reason you feel the report you will write will not help your patient's claim, you are usually best to first raise this with your patient. Open communication will usually be understood by your patient and will avoid any surprises.

The patient might then speak to his/her solicitor to explain the situation. If the report was requested by the solicitor, in many cases, the request for the report will be cancelled.

YOUR RECORDS AND REPORT MAY BE USED AS EVIDENCE

You should keep in mind that anything you write down in your patient's records could be used as evidence. Avoid writing irrelevant or defamatory remarks which may be embarrassing to you or your patient if ever the records appear in court.

YOU MAY BE CALLED AS A WITNESS

You may be called as a witness in your patient's case and could be cross-examined on the contents of your medical report. You should be satisfied you can justify the contents of what is written in your report. For more information see our information sheet "Checklist for giving evidence in Court".

COMPLY WITH LEGISLATION

The *Health Record Act* provides that if a request for clinical records is made, you must comply and give photocopies of all documents you hold, including examination and treatment notes, test results and copy correspondence to and from other treating health care professionals.

A fee of $34 can be charged (plus $16.32 if records stored off site) plus 20c per page copied. The only ground upon which you can refuse access is if you consider it may pose a serious threat to a person's health.

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LOCATIONS EPPING | MELBOURNE | MELTON | MOE | SPRINGVALE | WANGARATTA

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MAKE SURE YOU HAVE A SIGNED AUTHORITY FROM YOUR PATIENT

Before releasing any medical information about your patients, either by phone or in writing, you should insist on an original signed written authority by your patient. Keep this authority on your file as evidence of the patient's consent to release private health information. It is reasonable to require the authority to be dated and not more than 12 months old.

IF IN DOUBT, SPEAK TO THE SOLICITOR

If you are uncertain of what is required, speak to the solicitor.

Adviceline Injury Lawyers are always happy to answer any queries from health care professionals about the need for a report and to clarify what has been requested.