

Medical report template

Generic treating practitioner report for Australian clinicians

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STOP BEFORE DRAFTING: Verify and record the disclosure basis or authority and its scope. Patient consent or authority is one pathway. Keep it distinct from a court or tribunal order, statutory authority, primary-purpose disclosure, or a directly related and reasonably expected secondary purpose. Confirm the source, date, currentness, signatory and capacity where relevant, intended recipient, purpose, information scope and exclusions. Use a requester-mandated form when one applies.

This PDF contains labelled form fields in reading order. Save a completed copy and print only when needed. Use initials or a local record identifier in the repeating header.

1. Pre-drafting authority and scope check

Complete this section before drafting. If the basis or scope is unclear, pause the report workflow until it is resolved.

Authority or disclosure basis type

Select and describe one: patient consent/authority; primary-purpose disclosure; directly related and reasonably expected secondary purpose; court or tribunal order; statutory authority; other lawful basis.

Authority source

Signed authority, recorded discussion, order, notice, legislative provision or other source. Include document title or reference.

Authority or source date

DD/MM/YYYY

Currentness confirmed

Date checked, how checked and any expiry or limit.

Signatory or issuer

Name and organisation, or N/A.

Signatory capacity

Patient, substitute decision-maker, authorised representative, court/tribunal, statutory body or other capacity.

1. Pre-drafting authority and scope check (continued)

Intended recipient

Name, role, organisation and secure delivery destination.

Purpose and intended use

Why the report is needed and how the recipient will use it.

Information authorised or otherwise permitted

Condition, date range, questions and categories of information included.

Exclusions or limits

Information outside scope, conditions not covered, onward disclosure limits or other restrictions.

2. Report and patient details

Use only the identifiers needed for the purpose. Use initials or a local record identifier in the repeating header rather than a Medicare number.

Date prepared

DD/MM/YYYY

Requested by

Name, role and organisation.

Request date

DD/MM/YYYY

Report, claim or matter reference

Reference number, if applicable.

2. Report and patient details (continued)

Patient full name

Full legal name and any relevant known-as name.

Date of birth

DD/MM/YYYY

Other minimum necessary identifier

UR/MRN or local record identifier if needed. Do not add a Medicare number unless required for the purpose.

Repeating header identifier

Initials or local record identifier only.

3. Clinician details and relationship

Describe the author and the limits of their direct knowledge.

Author

Name, qualifications, role and provider number if relevant.

Practice or service

Name and contact details.

Relationship to patient

Treating role, whether usual clinician, date first seen and frequency of contact.

Date last clinically reviewed

DD/MM/YYYY and mode of review.

4. Sources and limitations

List each source used and make gaps visible.

Consultations relied on

Dates and clinician or service.

Medical record date range reviewed

Start and end dates.

Investigation reports reviewed

Investigation, date, reporting service and report reference where relevant.

Correspondence and other documents

Document, author, date and who supplied it.

Limitations and unavailable information

Missing records, elapsed time since review, reliance on patient report, unavailable examination or evidence, or 'No material limitations identified'.

5. Relevant clinical history

Include information relevant to the defined purpose and attribute patient-reported events.

Condition or issue covered

Name the condition or question covered by the report.

5. Relevant clinical history (continued)

Presenting condition and chronology

Relevant events in date order. Use 'The patient reports...' for events you did not observe.

Relevant past medical history

Include only information relevant to the purpose and scope.

Current medicines and allergies

Include only when relevant and verify against the current record.

6. Current clinical information

Distinguish patient report, observed findings, documents from others and your assessment.

Patient-reported symptoms and function

Symptoms, daily activities, work or study impact and change over time.

Examination and observations

Date, mode and objective findings.

6. Current clinical information (continued)

Investigations

Test, date, result and source. Quote sparingly and accurately.

Assessment or diagnosis

Diagnosis or differential, status and basis. State uncertainty.

7. Management and progress

Keep treatment facts separate from the patient's report of response.

Treatment to date and response

Intervention, dates, adherence if known, response and adverse effects.

Current management plan

Management, referrals, monitoring and review timing.

Prognosis or expected course

Give only within your expertise. State assumptions and uncertainty.

8. Responses to requested questions

Repeat each question, answer directly, give reasons and identify any evidence still required.

Question 1 and response

Question, direct answer, supporting evidence and reasoning.

Question 2 and response

Question, direct answer, supporting evidence and reasoning.

Additional questions and responses

Add further questions in the same format.

Further information required

Evidence needed before a reliable opinion can be given, or 'None'.

9. Declaration and sign-off

Review every statement against the listed sources before signing. Add supplementary information in a separately dated report rather than silently altering an issued report.

Declaration

I prepared this report from the sources listed above. I have distinguished patient-reported information, clinical findings, information from other sources and my professional opinion. I have reviewed the report and believe it is accurate within the limits stated.

Author signature

Sign after final clinical review.

Name and qualifications

Full name and relevant qualifications.

Date signed

DD/MM/YYYY

Attachments

List each attachment or 'None'.