THE DOCUMENTATION DEFENCE™

Complication and Incident Documentation Template

A calm chronology for unexpected outcomes, concerns, adverse events and complaints.

Educational prompt only. Adapt it to the patient, treatment, your profession, scope, current guidance, insurer terms, clinic policy and record system. This is not legal advice and does not certify compliance. Do not place identifiable patient information in an unsecured copy.

Patient / record reference	
Date, time and route of first contact	
Person receiving the contact	
Original treatment and date	

What happened

Record the patient's report, symptom or concern, onset and sequence. Make the source of information clear.

Patient report and chronology

What you observed

Record the assessment completed, responses, objective findings, relevant negatives actually checked and limits of any remote review.

Assessment and observations

What you did

Record the working view, uncertainty, action, consultation, treatment, escalation or referral within the real pathway.

Reasoning and actions

What you advised

Record the information, advice, safety net, help route and how understanding or refusal was documented.

Advice and patient decision

What happened next

Record the follow-up owner and timing, later change, review outcome and any applicable clinic, insurer, manufacturer, employer or professional notification.

Follow-up, outcome and reporting