THE DOCUMENTATION DEFENCE™

The Documentation Defence Checklist

Twelve questions to ask before you close a clinical record.

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.

☐	Does the current history and assessment make sense?
☐	Have I recorded what mattered to this patient?
☐	Can another reader see my clinical reasoning?
☐	Is the suitability, modification, deferral or refusal decision explained?
☐	Does the note show the meaningful consent conversation?
☐	Are applicable product, device, medicine and treatment details traceable?
☐	Is the aftercare specific enough to understand what was advised?
☐	Is the follow-up route, timing and owner clear?
☐	Are calls, messages, emails and photographs linked into the chronology?
☐	If something changed, can the record show what happened next?
☐	Are facts, patient reports and clinical opinion clearly distinguished?
☐	Is every entry attributable, dated, timed and transparent if added later?

The final read

Could an appropriate person who was not in the room understand what happened, why, what was advised and what happened next?

The one prompt I will add to my system
