THE DOCUMENTATION DEFENCE™

The 10 Documentation Red Flags

Ten common phrases that need patient-specific detail to become meaningful.

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.

Red flag phrase	Why it is weak alone	What to add
Consent obtained.	The conversation is invisible.	Important information, patient-specific concern, questions, understanding and decision.
Risks discussed.	The relevant risks are not identified.	Risks actually covered and anything that mattered particularly to this patient.
Patient happy.	The timing and meaning are unclear.	What the patient said or agreed, at what point, and any review plan.
Treatment carried out as planned.	The treatment itself is not described.	Applicable product, site, amount, technique, practitioner and observations.
Advised accordingly.	The reader cannot see the advice or safety net.	Exact advice, help route, review trigger and next action.
Fit and well.	It does not show what was checked.	Current history review, changes, medicines, allergies and relevant factors.
No concerns.	The source and assessment are missing.	Whose concerns, what was asked and what supported the statement.
Usual areas treated.	It describes habit, not this patient.	Actual sites, allocation and patient-specific reason.
Photo reviewed, all fine.	No objective finding or limitation is visible.	Time received, observations, remote-review limits, working view and plan.
Follow up PRN.	There is no trigger, timing or owner.	Agreed contact trigger, route, review time and responsible person.

The anti-template check

If the sentence could be pasted unchanged into every patient's record, ask what patient-specific fact, reasoning, conversation or next step is missing.

The red flag I use most often and the prompt I will add
