Assessment Grid of Clinical Documentation

Date: _____ Supervisor: _____ Trainee: _____

Rate only relevant behaviours:

5 = very good 4 = good 3 = satisfactory 2 = poor 1 = unsatisfactory

Rate	Behaviours to consider
	1. Conforms to set deadline for writing notes in the clinical file (policy, supervisor's request, professional standards, etc.).
	2. Complies with the expected documentation format.
	3. Identifies the document (each sheet) by the client's name, with accurate and complete information.
	4. Writes the anamnesis based on relevant, accurate, complete and well-organized data, in the appropriate chronological order.
	5. Provides accurate test results.
	6. Presents diagnostic data in the appropriate and expected format.
	7. Uses protocols and other raw data in a comprehensive manner and attaches a copy to the report or file.
	8. Notes clinical observations accurately and in expected parts of the document.
	9. Describes the client's level of functioning, based on recent diagnostic data; includes reference values, where relevant.
	10. Writes goals and objectives in terms related to behaviours.
	11. Sets goals and objectives tailored to age, disorder or problem and its severity.
	12. Summarizes progress for each objective.
	13. Provides concise and complete clinical impressions, including the nature and severity of the problem.
	14. Meticulously incorporates clinical impressions and information coming from other sections.
	15. Puts forward appropriate recommendations as related to age, problem, severity, based on available data.
	16. Uses terminology, spelling, punctuation and syntax (grammar) appropriately.
	17. Submits reports that contain no useless words, repetitions or other meanderings.
	18. Refers (cautiously) to comments that are beyond his field of practice.
	19. Articulates all information using a vocabulary that is tailored to the person who will receive the report.

Adapted from Ruder, Simpson, Ruder, McCabe Smith, Trammell & Landes, 1996, p. 116.

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