A clinic note form: chiropractic-medical correspondence

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This paper offers a "CLINIC NOTE" form which is simple to use, cost-effective, and expedient in relaying the necessary clinical information to a colleague, medical practitioner, medical specialist, employer, or insurer.

Introduction

Traditionally medicine and health care has been diverse, with poor communication between professionals and even ignorance about those outside their area of expertise. There has been little sense of cooperation and even suspicion between certain health care practitioners. Patients do not benefit from these attitudes nor does society as a whole.

In the nineteen-eighties there was a realization that no single professional nor specialty had all the skills necessary to treat each patient: especially in reference to musculoskeletal conditions. Multidisciplinary care was born out of this insight and has led the way for improved care of pain patients.[1] Although we as professionals are diverse, each one of us offers a potentially useful approach to the alleviation of pain and its control. In a collaborative setting, we are able to learn from one another and realize that each one of us has something to offer in responding to the enormously complex needs of pain patients.

During the nineteen-nineties, it has become evident that the barriers between the medical and chiropractic professions are dissolving as we see more and more medical-chiropractic practice settings and increased collaboration between the two professions. There has been an increase in the number of medical referrals to chiropractors, which will continue. The recent Manga Report, recommends to the Ontario Ministry of Health that they take all reasonable steps to actively encourage cooperation between chiropractors, medical doctors and physiotherapists.[2]

In this setting of increasing cooperation and interaction between our professions, it is essential to have direct communication and accurate records. The purpose of this paper is to discuss a method of standardized report writing to ensure the goal of interdisciplinary communication.

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Objective

The object of this paper is to describe report writing in a unique aspect. Other authors have already described thoroughly how to write a report when referring a patient to another health care provider.[3,4] In this paper, a CLINIC NOTE form is proposed that can be used to thoroughly summarize your clinical examination findings, clinical impression, treatment regime and prognosis. It is not intended to replace the formal dictated note.

Two factors encouraged the development of this form. The first arose after opening two satellite chiropractic clinics in association with well established medical clinics, a method of informing the doctors about their patients was needed. To assist me in communicating with the medical doctors in an efficient manner, the proposed format was developed. The second reason, was that a significant number of chiropractors do not frequently write reports. A standardized form may help provide all the pertinent information in an easily understood manner.

Further, with good reporting, chiropractors can educate their medical colleagues about matters related to the diagnosis and management of neuro-musculoskeletal disorders. Chapman-Smith writes, "written communications provide the most potent form of market visibility and advertisement of ability for professionals".[5]

Recent literature now supports chiropractic manipulation as a viable and efficacious form of conservative treatment of back pain.[6,7,8,9] Medical doctors will begin to refer more patients to chiropractors. A medical practitioner may judge a chiropractor's level of expertise initially from their clinic note or letter of referral. This may lead to more referrals as observed through personal experience. A busy medical doctor appreciates having a conscientious chiropractor manage their patients, and will value your evaluation and subsequent treatment. In addition, they will feel at ease, and have a record of it in their patient file.

The clinic note

The clinic note form should include the following components:

1. Chief complaint.
2. Pertinent clinical examination findings
   a) History
   b) Physical examination (including orthopaedic and neurological testing).
3. Radiological examination findings.
4. Clinical impression.
5. Recommended treatment program.

CLINIC NOTE

TO:_____ FROM:_____

WCB#_____ MVA:_____ DOB:_____

PATIENT NAME:_____ DATE:_____

CHIEF COMPLAINT:_____

PERTINENT CLINICAL FINDINGS - HISTORY AND EXAMINATION:_____

RADIOLOGICAL EXAMINATION: _____

CLINICAL IMPRESSION: _____

RECOMMENDED TREATMENT PROGRAM: _____

PROGNOSIS: _____

_____

Examining Doctor

CLINIC NOTE

TO: Dr. G. Jones FROM: Dr. R. Guerriero

WCB#: MVA: Sept. 1, 1993 DOB: 5/6/33

PATIENT NAME: Mrs. D. Smith DATE: 3/9/93

CHIEF COMPLAINT: 1. Neck pain and stiffness 2. Headaches

PERTINENT CLINICAL FINDINGS - HISTORY AND EXAMINATION: General health – good

1. Hyperextension-type injury; no loss of consciousness, belted, prior history of neck pain, 4 years ago.

Asymptomatic day of accident.

2. C-spine ROM – Flex/ext by 50%, ® rot'n and lateral bending ↓ by 75%

3. Kemp's test – positive at C5/6 – indicating facet joint irritation

4. Neurological exam – upper limbs/cranial nerves – within normal limits

5. Hypertonic muscles – scalenes, post. cervical m, suboccipitals.

6. Spinal fixations in the cervical and thoracic spine

RADIOLOGICAL EXAMINATION: C-spine series 4/9/93

Reveals moderate DDD at C5/6 and alordosis of the normal cervical curvature

CLINICAL IMPRESSION: 1. Second degree cervical facet joint sprain C5/6

2. Second degree cervical myofascial strain, uncomplicated

3. Muscle contraction-type headaches

RECOMMENDED TREATMENT PROGRAM: 1. Electrotherapy e.g. IFC

2. Chiropractic manipulations 3. Soft tissue massage

4. May need a functional restoration program, if indicated in the next 4 – 8 weeks

5. Cervical pillow, home cryotherapy

6. Off work – 2 weeks – will re-evaluate

PROGNOSIS: Good. She should reach full functional recovery within 3–4 months.

Targeted return to work date: 17/9/93.

Examining Doctor

6. Prognosis.

A sample of the clinic note form is shown in figure 1. Figure 2 is an example of a completed clinic note form.

Some important points to consider when using this form:

1. The medical doctor (MD) spends probably less than 30 seconds reading it, so keep it brief and concise.
2. Indent the findings so that the subject headings stand out.
3. Use language the medical doctor can understand, i.e. spinal fixation (hypomobile joint) or intervertebral joint dysfunction, instead of subluxation.[4]
4. Give a diagnosis (i.e. clinical impression) that is commonly used, e.g. lumbosacral sprain, disc herniation L5/S1, myofascial pain syndrome – paraspinals etc.[3] The clinical impression is probably the first place the clinician will focus when reading this form. So make it short, comprehensible and noticeable.
5. A good thorough history and physical examination is the key to proper diagnosis, however this form is intended only to include the most significant findings:
   a) History
      i) Location, duration, onset and intensity of pain, aggravating/relieving factors;
      ii) Previous illness/surgeries;
      iii) Systems review;
      iv) Present medications;
      v) Lifestyle;
      vi) Family history.
   b) Examination findings
      i) Ranges of motion;
      ii) Pertinent orthopaedic tests: e.g. nerve root tension signs;
      iii) Neurological examination;
      iv) Soft tissue palpation findings (e.g. scalene muscle spasm) and motion palpation findings (e.g. spinal fixations/hypomobile joints throughout the lumbar spine).
6. Do not include negative findings on this report. That is, include all the pertinent positive findings and at the end you can write, "otherwise unremarkable". However, in your patient charts, make sure that all the tests performed are included even if they are negative!
7. Some chiropractic/orthopaedic tests are unfamiliar to the medical doctor, so include the significance of the test (e.g. Kemp's test – positive at C6/7, indicates facet joint irritation) or generalize your findings (e.g. cervical compression test – indicates facet joint irritation).
8. Complete the clinic note within a few days of the referral.
9. In the prognosis, include what percentage of improvement you expect from your treatment and approximately how long it will take for the patient to reach functional recovery.
10. Include all aspects of the recommended treatment program, e.g. modalities, ice, manipulation, rehabilitation. Also, include the expected frequency and duration of treatment.

Conclusion

This clinic note form may be used very effectively to help keep charts legible and complete. It can be used as a quick and thorough "thank you" note sent to referring chiropractors, medical doctors, and medical specialists. It can be used to update clinical findings in a presentable and efficient manner, thus keeping the referring practitioner or insurer informed on the patient's progress. Finally, this form can be used as a 'work sheet' to summarize the history and examination findings, so that later a more comprehensive medical report can be dictated.

This clinic note form is not intended to replace the formal letter or medical-legal style report. Cassidy et al. have provided an excellent framework for writing formal dictated reports.[3] A good clinic note is only as good as the clinician. Putting thoughts on paper will stimulate you to think and sort out your differential diagnosis. This form will make it easier to write reports, keep better and more concise patient records, and continue to encourage interprofessional communication.

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