Northwestern Medicine

Clinical Note Writing Tips

It is best practice to document clearly, accurately and specific to the patient's situation at the time of the encounter. And, since HIPAA entitles virtually all patients to obtain copies of their complete medical records at any time, it is important to write notes with the assumption that patients may read them. Below are tips to streamline your notes:

- **Avoid jargon, abbreviations and acronyms:** Briefly define or simplify medical terms. Spell out acronyms.
- **Provide a balanced perspective:** For behavioral health issues, describe the patient's strengths and achievements along with documenting clinical concerns to give the patient broader context.
- **Include difficult conversations:** If it's important enough to talk about, include it in your notes. Being on the same page with a patient can build trust.
- **Convey information** instead of just providing data. If you use Family History or Social History Smartlinks, specify in the note for what the patient is at risk, based on new information obtained during the visit.
- **Use the correct pronoun** to describe the patient.
- **Use objective language instead of opinions and judgements**
- **Avoid copying and pasting without editing** to improve note relevance and reduce length
- **Describe the condition, instead of using a label:** "Has diabetes" instead of "diabetic."

Language Recommendations

Instead of …	Consider alternate wording
Highly anxious, drug-abusing patient	**Patient uses injection drugs. Or patient has a drug disorder.**
Stinks of alcohol and intoxicated; caused a car accident	**Tests positive for alcohol, in setting of car accident**. Include if true and discussed with the patient.
Patient refuses to take his pills	**Patient has been non-adherent to therapy, or patient has had difficulty tolerating, or patient cannot afford medication.**
Shows symptoms of major depression and has had thoughts of suicide	If mental health symptoms are discussed openly, include them. Open psychiatry notes can increase patient trust.
Patient is paranoid, but won't acknowledge it	Provide examples without judgement.
Morbidly obese	**Obese per medical criteria.** Studies indicate patients often react positively to thoughtful discussion pointing to its relation to other conditions.
Patient was SOB	**Patient was short of breath**. Use EHR auto-correct dictionary tools to auto-expand commonly misunderstood acronyms.
GI service refuses to scope the patient	**Continue discussion with Gastroenterology about endoscopy timing**. The medical record is not a place for turf wars or venting.
F/U	**Follow-up**

HIPAA permits patients to request an amendment to their medical record if they believe information is inaccurate or incomplete. If a patient submits a request to amend documentation you authored, you will have an opportunity to review the request to determine if it should be approved or denied.

View more information and resources about patient transparency at NM on **Physician Forum** and **NM Interactive**.