

# READING GROUP

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# GUIDELINES

**The working group recommends that all physiotherapists (both employed and freelance, irrespective of their type of activity) should start a record for every patient and keep it up to date.**

It is recommended that, as far as possible, this record should be incorporated into a medical record or into a single record designed to be used by all healthcare personnel.

**It is recommended that the record be designed in such a way that it is appropriate for the procedures, the activity and the context of each professional or care centre. However, the following rules should be observed:**

- the person who completes the record should be identified;
- the record should be structured and simple to use;
- it should use precise, clear language and an understandable vocabulary;
- it should contain information specific to the practice of physiotherapy;
- record management should preserve the confidentiality of patient data.

**A physiotherapy patient record should contain the following information:**

## 1. Social and administrative information

Record number	Desirable
<b>Surname</b>	<b>Required</b>
<b>First name</b>	<b>Required</b>
<b>Sex</b>	<b>Required</b>
<b>Date and place of birth</b>	<b>Required</b>
<b>Address</b>	<b>Required</b>
Telephone	Desirable
<b>Profession</b>	<b>Required</b>
Family situation	Desirable
Environment - lifestyle	Desirable
Sports and other activity	Desirable
<b>Name of person insured</b>	<b>Required</b>
<b>Social Security number</b>	<b>Required</b>
Person to contact (father, mother, guardian, etc.)	Desirable
Details of private health insurance	Desirable
Date of request for reimbursement, made prior to treatment (DEP)	Desirable
Method of transport	Desirable
<b>Date of first session</b>	<b>Required</b>
<b>Date of last session</b>	<b>Required</b>
<b>Name of physiotherapist</b>	<b>Required</b>
Others involved	Desirable

## 2. Medical information

<b>Medical diagnosis</b>	<b>Required</b>
<b>History of the disease</b>	<b>Required</b>
<b>Medical problem(s)</b>	
– requiring admission to hospital	<b>Required</b>
– requiring physiotherapy treatment	<b>Required</b>
– other medical problem(s)	Desirable

History  
medical  
surgical  
physiotherapy  
family

## Reports

examinations (imaging, functional investigations, etc.)

surgical  
hospitalisation  
consultation

Current treatment

Medical prescription of physiotherapy treatment

Prescribing doctor

## 3. Patient's expectations

## 4. Physiotherapy examination

Containing sheets for updated assessments  
(names of patient and physiotherapist given)

## 5. Physiotherapy diagnosis

## 6. Aims of physiotherapy treatment

Including in particular:

- treatment objectives and priorities
- deadlines by which the objectives set are expected to be achieved

## 7. Physiotherapy treatment

This contains details of the physiotherapy treatment:

- therapeutic, preventive and educational strategy
- techniques described according to the *nomenclature générale des actes professionnels* (official French classification of items of treatment) or PMSI codes (*Programme de Médicalisation du Système d'Information* - official French medical management program)

The keeping of a treatment session record card for follow-up is recommended.

## 8. Results of treatment – Evaluation

## 9. End of treatment report

## 10. Professional correspondence

The record should be accessible at all times during treatment.

The working group recommends that the record should be the focus for handwritten or computer communication involving the patient, the referring doctor and other health care and social care personnel involved.

Desirable  
Desirable  
Desirable  
Desirable

Required

Required

Desirable

Desirable

Desirable

Required

Required

Required

Required

Required

Required

Required



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d'Évaluation en Santé

## CLINICAL PRACTICE GUIDELINES

# PATIENTS RECORDS IN PHYSIOTHERAPY

February 2000

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