

	DOCUMENT NAME	DOCUMENT NUMBER
	PATIENT RECORD AUDIT CHECKLIST – COMMUNICATION OF DIAGNOSTIC RESULTS	

VERSION	1	
COMPILED BY		DATE 07/2025
AUTHORIZED BY		
NEXT REVISION DATE		07/2027

#	Review Item	Verified (Yes/No)	Notes
1	Diagnostic investigation result is on file		
2	Doctor has reviewed the result (signed/annotated/stamped)		
3	Documentation that the user was informed of the result		
4	Method of communication noted (e.g. in-person, telephone, SMS, email)		
5	Follow-up discussion or action based on result (if needed) recorded		
6	Date the user was informed is clearly documented		

Acceptable Documentation Examples:

- “Informed patient of normal blood results in consultation today – no further action. – Dr. Mbatha 15/03/2025”
- “Telephonic communication with user on 10/04/2025 – explained cholesterol results. Advised lifestyle modification.”
- “Results discussed during follow-up consultation on 02/05/2025 – infection resolved. Antibiotics completed.”

Non-Compliant Indicators:

- Results filed with **no note** about communication to the user
- Record shows clinical action taken based on result, **but no documentation** that the user was informed
- “Seen and discharged” without linking back to the investigation result

Good Practice Tip:

Develop a “**Results Communication**” **template/section** in patient notes (manual or EMR) where clinicians must tick/record:

- How result was communicated
- What was discussed
- Date of communication

