	DOCUMENT NAME	DOCUMENT NUMBER
	RESPONSE TO DIAGNOSTIC INVESTIGATION RESULTS	

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

What Must Be Documented:

After a diagnostic result is received and reviewed, the health care provider must clearly record:

Requirement	Description
Date	When the result was reviewed and action was taken
Result Summary	A brief note of the key findings (e.g., elevated WBC, abnormal ECG, etc.)
Clinical Action Taken	What steps were taken (e.g., medication adjustment, referral, repeat test, lifestyle advice)
Follow-up Instructions	Any follow-up appointments, investigations, or monitoring required
Provider Signature	Signature or name of the provider who took the action
Patient Notification	Confirmation that the patient was informed (ideally linked to prior standard)

📝 **Acceptable Documentation Examples:**

- "Bloods show low Hb (9.2). Iron supplementation prescribed. Recheck in 2 weeks. – Dr. Patel 14/04/2025"
- "ECG: Sinus bradycardia noted. Referred to cardiologist. Appt scheduled for 25/06/2025. Informed patient. – Dr. Molefe"
- "HIV test reactive. Counselling provided. Initiated ART today. – Nurse K. Mokoena"

❌ **Non-Compliant Examples:**

- Result is filed but **no note** or action plan recorded.
- Action was taken (e.g., patient referred or started on meds), but **no link to the investigation** is documented.
- EMR entry says "Seen" or "Reviewed" without specific clinical response.

🔐 **Risk Rating: Vital Measure**

Failure to document the action taken in response to diagnostic results can be interpreted as **clinical negligence** or **incomplete care**, especially if the result is abnormal or has safety implications.