RACGP

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ReCEnT: Instructions for completing the 'Encounter Form'

Introduction

These instructions support your participation in the ReCEnT project and outline how to accurately complete each component of the Encounter Form.

General Instructions

Complete all parts of the form

Some items are mandatory and marked with a red asterisk.

Complete all sections relevant to the consultation—for example, record medications prescribed, referrals made, and any pathology ordered. More complete data leads to more useful feedback.

Consecutive consultations

Complete a form for each of 60 consecutive clinical encounters. The only exception is when a patient returns later the same day for review—record this as one consultation.

Forms must be completed during your allocated data collection period.

Record every consecutive encounter, including complex ones, to avoid biasing your feedback report.

Only include consultations in the general practice office setting. Do **not** record nursing home visits, home visits, or specialised clinics (e.g., immunisation, flu clinics, Women's Health).

If you work across multiple practices, you'll be told which practice to use for all 60 encounters.

You do **not** need to discuss the project with patients, obtain consent, or document anything in their notes.

More information than the form allows?

Record up to four problems. If more were managed, select the most clinically relevant

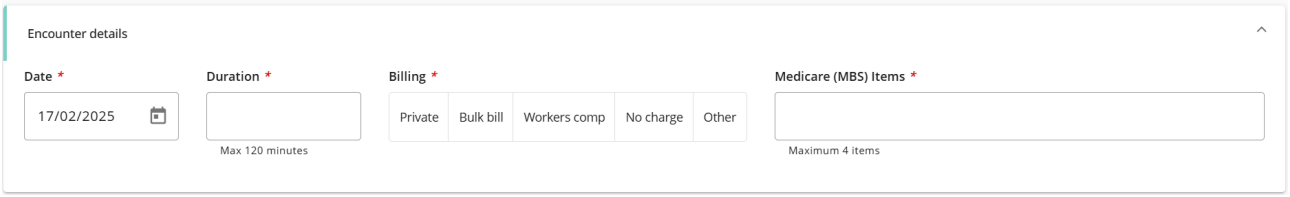
Abbreviations/Acronyms

Unless it is a very well established abbreviation or acronym, please write out in full. For example, SCC always means squamous cell carcinoma, but SK could mean solar kerotosis or seborrhoeic kerotosis.

Completing the encounter form

You will be familiar with the format of the encounter form from your ReCEnT project orientation session. The following is a reminder on how to complete each element of the form. Some elements are self-explanatory and therefore not included below.

Encounter details



Date

This is the date of the encounter. It defaults to the current date, but you can override that manually.

Duration of Consultation

- Record the consultation duration **to the nearest minute**.
- Maximum recordable duration is **120 minutes**—enter 120 if it exceeds this.
- **Tips:**
  - Use your medical record software's timer.
  - Don't round to 5-minute increments.
  - Include note-writing time as well as patient contact time.

Billing

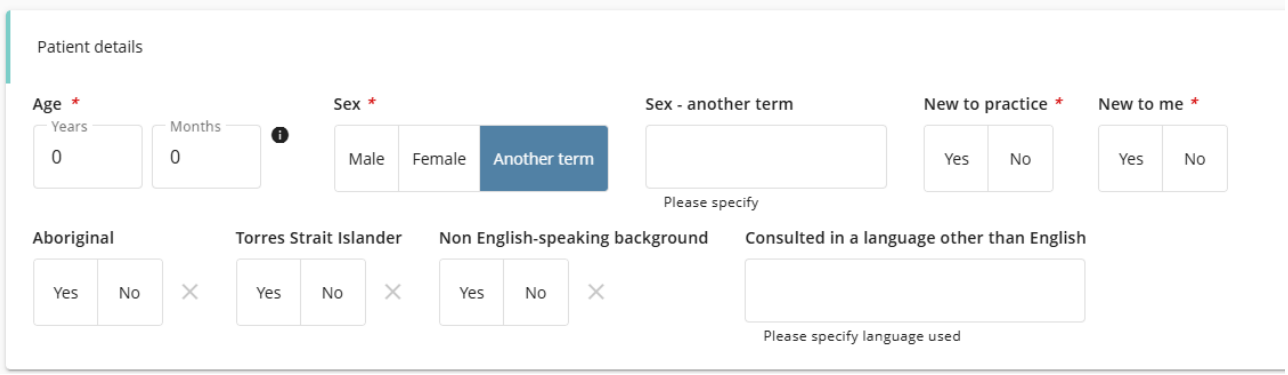
- **Private**: Click this box if the patient paid a co-payment.
- **Bulk Bill**: Click this box if the visit was bulk billed.
- **Workers Comp**: Click this box if the visit was covered under WorkCover.
- **No Charge**: Click this box if the visit was free to the patient and there was no Medicare billing.
- **Other**: Click this box if the encounter is being paid for by another source e.g. insurance company, overseas patient, work or employment medical.

Medicare (MBS) Items

Please record Medicare Benefit Schedule (MBS) or WorkCover item numbers as appropriate. Only include item numbers for services provided to the patient in your consultation rooms or using telehealth.

Note: Home visits, nursing home visits, or consultations where the patient is not involved (e.g. case conferences) should **not be included** as an encounter.

Patient demographics



Age

Record the age in years only for adults and children 2 years and older. Under 2 years record the age in months only. If under 1 month then the age is 0 years and 0 months.

Sex

The options are 'female/male/another term'. If the choice is 'another term' then an optional text box is available to record further detail. We recommend that you use the value recorded for patient sex in your practice's medical record.

Aboriginal and Torres Strait Islander

If your patient's record does not identify Aboriginal or Torres Strait Islander status, please ask the patient 'Do you identify as an Aboriginal or Torres Strait Islander?' and click the boxes as appropriate. The patient may answer 'Yes' to either or both.

For more information on identification of Indigenous status, see the following link
http://www.healthinfonet.ecu.edu.au/health-facts/health-faqs/identification

Non-English Speaking Background (NESB)

To identify NESB status, please ask the patient 'Do you speak a language at home other than English?'. If the patient is from a NESB i.e. primary language spoken at home is NOT English, click the 'Yes' box. Otherwise, click the 'No' box. You will have to directly ask about the language spoken at home to obtain this information.

Consultation where you spoke a language other than English

If **you** spoke a language other than English during the consultation, record the language. Only complete this section if **you** used the language for clinical communication—exclude cases where a translator was used or when you only used a brief greeting.

Consultation factors

New patient to practice

If this is the patient's first visit to this practice, click the 'Yes' box. Otherwise, click the 'No' box.

New patient to registrar

If this is the first time you have seen the patient, click the ‘Yes’ box. Otherwise, click the ‘No’ box.

Problem/provisional diagnosis

- Record your **single most likely** provisional diagnosis; use separate boxes for separate problems (1–4 total).
- **Do not** list differentials or use question marks.
- Use **one box per problem** and be as **specific** as possible (e.g., IDDM vs NIDDM).
- If uncertain, you may record **ill-defined**, **preventive**, or **social** problems.
- Only record problems **managed at this encounter**; order does not matter.
- If >4 problems, record the **four most representative** ones.

Problem status

- Select **New** if the problem is
  - new to the patient,
  - a new episode of a recurrent issue (e.g., UTI),
  - or has never been assessed by any medical practitioner before.
- Select **Old** if the patient has previously been seen by any practitioner for this chronic problem, its acute episode/exacerbation, or this acute problem.

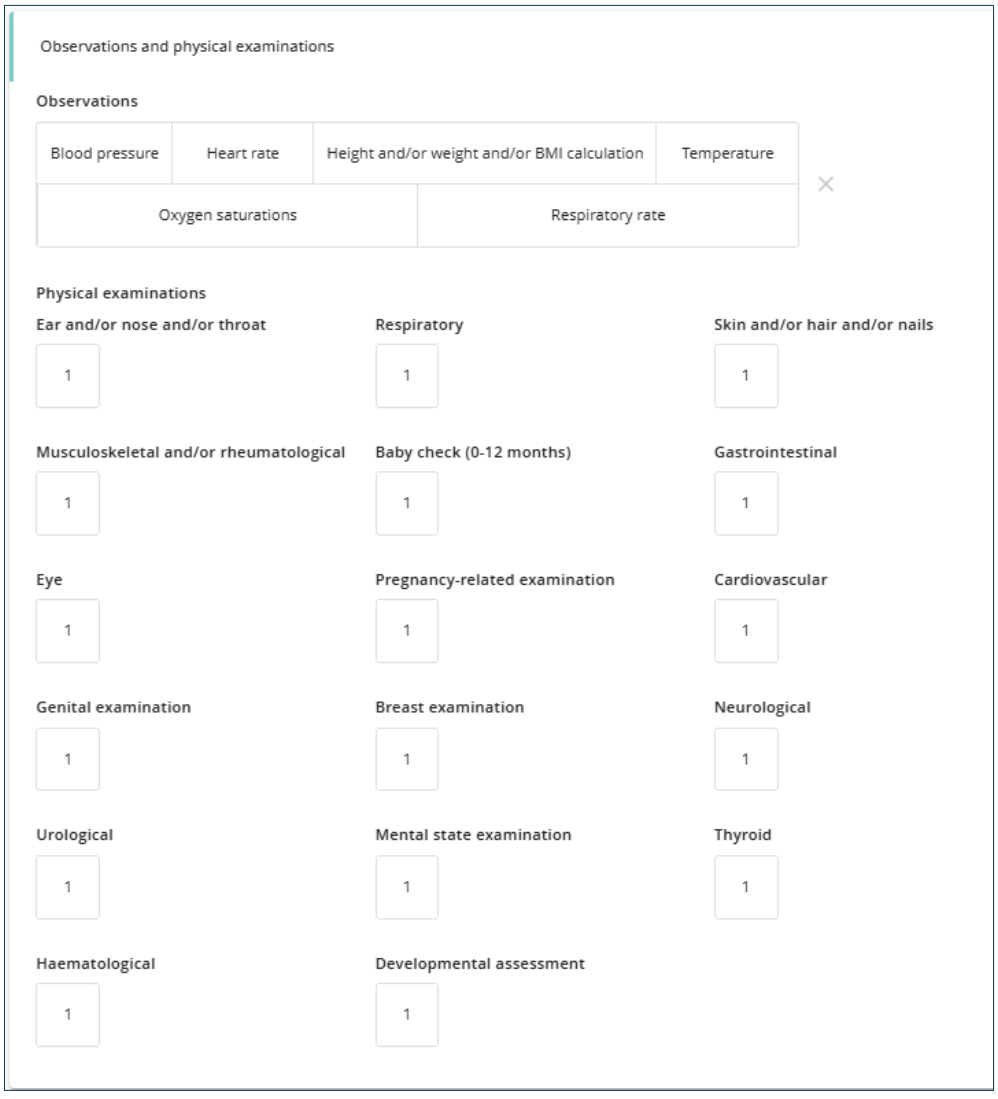
Seen by you for this problem before

If you’ve seen the patient for this problem **before**, select **Yes**; otherwise select **No**.

If the patient is **new to you**, the “Seen before” field will automatically fill as **No**.

Observations and Examinations

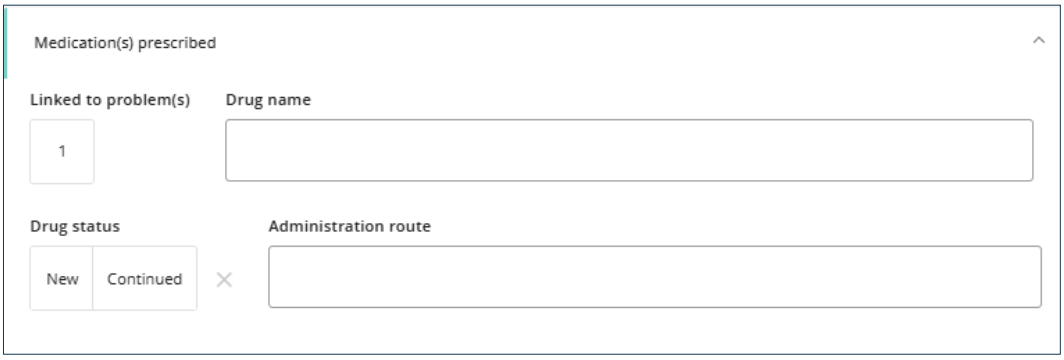
- Complete this section for **all** consultations, including telehealth.
- Select the **observations**, **systems examined**, and the **related problem(s)**.
- Record **any** examination you perform, even if brief or targeted.
- Choose all relevant systems when an exam spans multiple areas (e.g., ENT + respiratory for URTI).
- Don't under-record—this ensures accurate reflection in your feedback report.



Medications prescribed

- Record medications when you **prescribe**, **recommend an OTC**, or **administer/supply** a medication or vaccine (including samples).
- Link each medication to the relevant **problem number**.
- Enter the **drug name** and **route of administration** (e.g., Nexium tablets PO, metoclopramide IM). For vaccines, record the **brand name**.

- Mark the medication as **New** (first time for this problem) or **Continued** (ongoing/repeat therapy).



Medications deprescribed

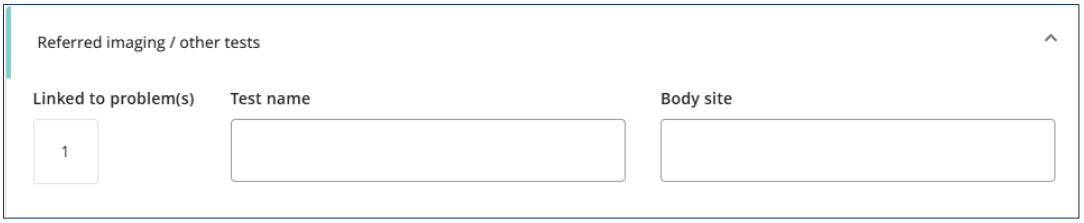
- Deprescribing includes medications that were **ceased or reduced with the intention to cease**.
- Record each deprescribed medication and **link it to the relevant problem**
- Indicate whether the patient had been on the medication for **<3 months or ≥3 months**.
- **Only record medications deprescribed at this encounter.**

Pathology

- Record pathology tests ordered at the encounter; **one test per box**.
- For single tests, write the **test name** (e.g., HbA1c).
- For grouped tests (e.g., FBC, LFT, lipids, TFTs), record the **group name only**—no need to list individual components.
- **Do not** record non-MBS panels/screens
- **Do not** record urine dipstick tests or capillary glucose measurements.
- **Link each test** to the relevant problem number(s).

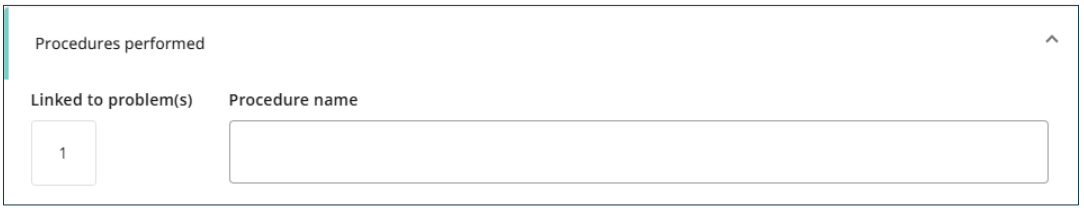
Referred Imaging/other tests

- For imaging, record the **test name** (e.g., x-ray, ultrasound) and **body site**, and select the relevant problem number(s).
- For other referred tests (e.g., nerve conduction studies, allergy testing), record the **type of test** and link it to the appropriate problem number(s).
- Include ECG or spirometry **if referred**, not performed.



Procedures

- Record **only procedures you performed or assisted with** during the encounter (e.g., skin excisions, biopsies, dressings, ECG, spirometry, cervical screening tests, injections, ear syringing).
- Enter **one procedure per line** and link it to the relevant problem number(s).
- **Do not include** routine history, basic exams (e.g., BP checks), routine urinalysis, or any referrals, imaging, pathology, or tests ordered.
- Exclude ECG or spirometry if they were **requested** rather than **performed**.
- Record procedures here **even if also listed as diagnoses** (e.g., cervical screening tests, immunisations).



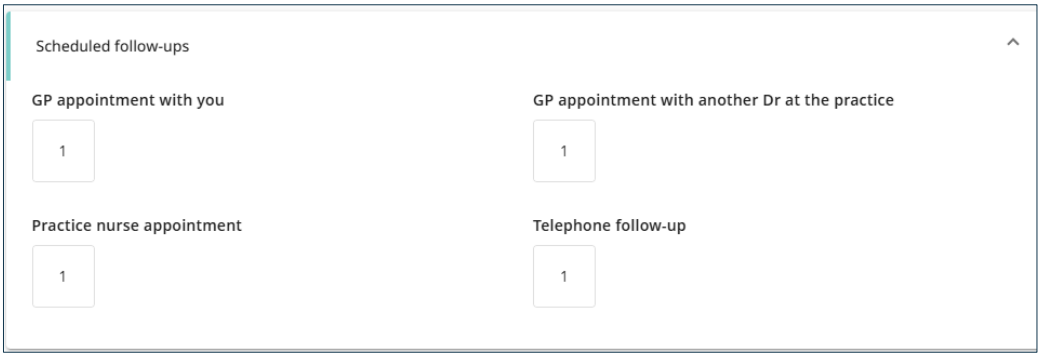
Referrals

If you refer the patient to another practitioner, record **who** you referred them to and **for which problem**. For example, a referral to a private physiotherapist should be entered as “Private Allied Health – physio” and linked to the relevant problem number(s).

Scheduled follow up

For each problem, record the plan for **scheduled** follow up.

- Do **not** record 'safety-netting', eg telling the patient to come back if they get worse, or are concerned etc.
- More than 1 option may apply for some problems.
- Please only click the problems for which **formal** follow-up is scheduled.

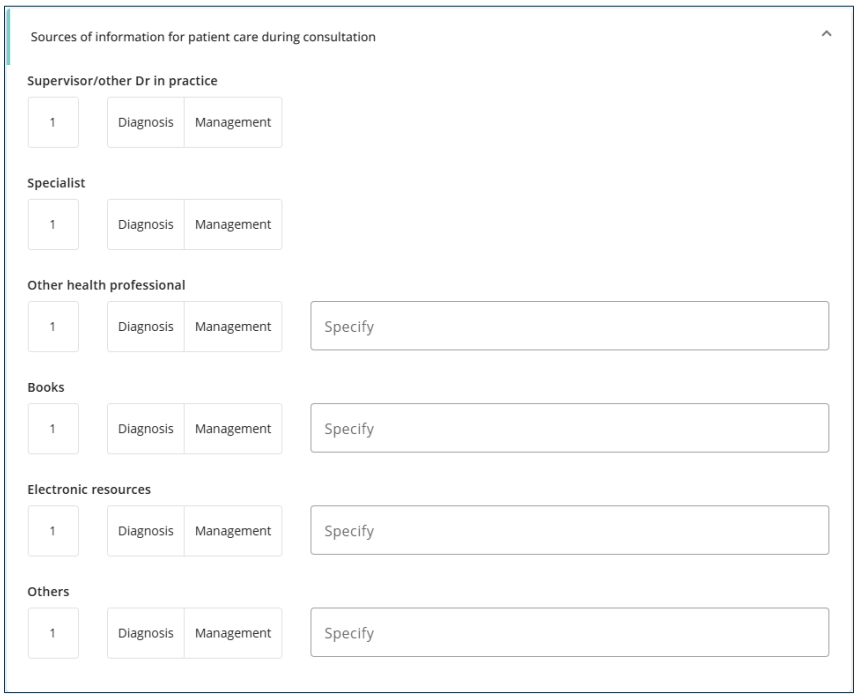


Learning Goals

- Learning goals are **educational outcomes arising from the clinical encounter**.
- They **exclude** information accessed **during** the consultation (that goes in *Sources of Information*).
- They refer to **plans to look up information or seek advice later**.
- Click the **relevant problem(s)** for any learning goals.

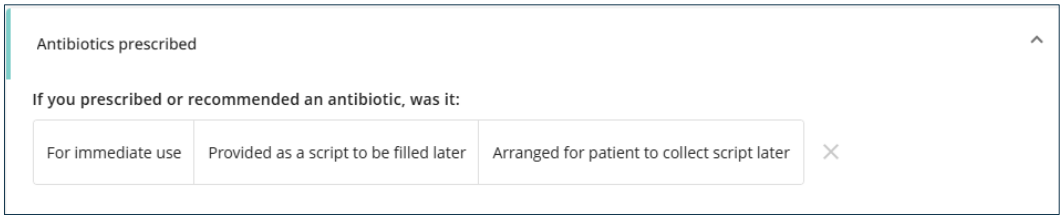
Sources of Information

- Indicate any information or assistance you used during the consultation, including the source and relevant problem number(s).
- Be specific, especially for electronic resources and clinical guidelines.
- You may select more than one option per problem.



Antibiotics Question

Complete this question only if you prescribed or recommended an antibiotic at this encounter, otherwise leave blank.



Finishing the form

- Click **Submit** to finish entering data.
- Click **Save** to return and complete the form later.
- Click **Reset** to clear the form and start again