Report writing Guidelines for SACNA Credentialing Process

SACNA does not want to be prescriptive as to report layout and is supportive of credentialing applicants developing their own style. Moreover, reports need to be skilfully tailored according to the nature of the referral question and purpose of the assessment. A report for clinical purposes with feedback to a medical professional, for instance, usually requires less fine detail than a report compiled for medico-legal purposes. However, the following core areas should be covered although not necessarily in the order and structure indicated:

Identifying data on the writer:

The letterhead must comply with the required HPCSA prescriptions, that is name and surname, qualifications, registration category, and appropriate contact detail. There should be no misleading claims regarding specialist expertise.

Identifying data on the patient:

This should include: Name and surname, age at time of assessment, date of birth, date/s assessed, date & age at insult, agent of referral, home language, educational level, handedness, occupation (Some want address and contact numbers, others want an explicit statement of race).

Reason for referral:

This should be a brief statement identifying the purpose of the report (e.g. educational assessment, readiness to return to work, medico-legal, etc). Sources of information: This should detail documents read and people interviewed or consulted telephonically. The report (or an attachment specifying results) should also state which tests and norms were used. Tests should be grouped under functional domains. Norm information should include (where possible) the names of the researchers, date of study and any other relevant details about the sample (e.g. gender, age range, educational level, quality of education, SES, race, first language, IQ level).

Medical history:

The chronology of events and the severity of the condition being investigated should be logically detailed. The sources of this information should be clearly stated.

Previous Medical and Psychological reports:

Provide a list of previous relevant documentation with name and date of origin. It may be relevant to provide a synthesis of the conclusions for integration into the final opinion of your report.

Family history:

This should include an educational history (including learning problems) and occupational history of parents and sibling. The educational and occupational history of a wider network of biological relatives (such as grandparents, first cousins, uncles and aunts) may be given, but only if this provides additional useful background for estimating premorbid intellectual function. Highlights of the medical and psychiatric history should be included.

Personal background:

This should cover the development history, educational achievements, occupational history and responsibilities, marital and parental details, socioeconomic circumstances, and social activities and hobbies; medical and psychiatric history. Descriptions of the person's basic personality as articulated by others may be included in this section. 2

Current complaints:

The layout of this will vary according to the condition being investigated and the patient. Complaints might be in order of importance as presented by the patient, followed by what was elicited on questioning, and should be operationalized with concrete examples from the client's life. If there are many complaints, sub-headings, such as Physical, Cognitive, Emotional/ Behavioural and Social, may prove helpful. Who is presenting the complaint (patient/collateral), its frequency, duration and severity, as well as aggravating and mitigating factors, should be clearly indicated.

Clinical impression/mental status examination/behaviour during testing:

This should cover appearance (striking features such as limp, slurred speech, lack of personal hygiene, etc), orientation, attitude to deficits and assessment, co-operation, effort, and predominant mood. We should also be told what is not there, so that it is clear that relevant questions were asked or clinical observations made (e.g., that there was no indication of psychosis).

Test findings:

- Explanation of test choices (e.g., the focus was on attention, memory and executive functions)
- Develop your own layout, but information indicated under relevant domain headings (e.g. attention and mental tracking, speech and language, motor functions, executive functions, etc) is helpful.
- Actual results need to be available to the examiners. These may be integrated in the text, placed as footnotes, or provided a supplementary document
- Comment is also needed on what is not present, particularly if a specific syndrome is being investigated (e.g., there was no left-sided neglect).

Conclusions:

This should be an integration of the reason for referral, the presenting condition, current complaints, interview and documentation information, clinical observations and test findings. The referral question should be answered. The conclusion must be a synthesis with implications in terms of brain behaviour relationships and should not just be a regurgitation of material laid out in the body of the report. It should not contain any new factual information that has not appeared earlier in the report. The conclusion may be the only aspect of a report that is read by the referral agent and should provide a synthesis of the whole case. It must provide a clear opinion and guidance on the way forward for the referral agent. If the opinion is that the outcome is uncertain, then the reasons for this uncertainty must be given. In other words there must be stated certainty about the uncertainty, rather than leaving the referral agent no further along the road in terms of need for the evaluation.

Recommendations:

These would be determined by the problems present and what can be done to mitigate them. These may be specified under a number of relevant subheadings, which may include medical (neurological, psychiatric), psychological (cognitive, emotional, behavioural), educational, occupational, familial, and social.

General comments:

Presentation:

Does the letterhead and whole report create a positive impression? Is the format such that it is easy to read (font size, line spacing, etc) and is the information easy to find? Has the report been proofread? Documents submitted to attorneys electronically need to be in a PDF format so that they cannot be altered. This would not apply to documents submitted for credentialing as some examiners may wish to comment by annotating the report. Is the report signed?

Content:

The referral question and referral agent must be clear. There must be sufficient detail to give an indication of the suspected neuropsychological condition and its severity. There must be sufficient history to determine who the subject of the report was prior to the onset of the condition, and sufficient information to ponder differential diagnoses.

Has appropriate clinical and other collateral information been obtained? What are the hypotheses regarding possible "clinical syndromes"? How is the information from collateral sources interpreted and related to these syndromes? Are clinical and psychometric measures used appropriate and the results interpreted reasonably?

Is the material interpreted in an integrated and comprehensive manner? Are various hypotheses/differential diagnoses tested, evaluated and interpreted in terms of the referral question? Are reasonable and empirically based conclusions derived from the interpretation of the elicited data? Is the referral question answered? Are reasonable recommendations, based on the derived answers, then made?

Typically there are four basic questions to answer:

- What could this person do (and who was this person) prior to the event?
- What happened?
- What are they able to do (and who are they) now?
- What are the various implications of this for their future?