Chinese Medicine Board
Ahpra

Guideline

1 July 2025

Guidelines on patient health records

Introduction

These guidelines state the Chinese Medicine Board of Australia's (the Board's) expectations on the appropriate standards for making patient health records and describe the minimum requirements of how Chinese medicine practitioners, and those seeking to become registered in the profession, should maintain patient health records.

These guidelines should be read in conjunction with the information provided in the Board's *Code of conduct*.[1]

To facilitate safe and effective care, health practitioners are expected to create and maintain health records that are in the best interests of patients and that contribute to the safety and continuity of care.

Patient health records are expected to be accurate, legible and clear, and contain sufficient detail so another health practitioner could take over the care of the patient[2] if necessary. They should include an accurate reflection of all consultations and other interactions relating to the clinical care and/or management of the patient, made at the time these consultations and interactions occur.

Who needs to use these guidelines?

The guidelines apply to all registered Chinese medicine practitioners, and anyone working under their supervision.

They will be used as evidence of what constitutes appropriate professional conduct and practice for Chinese medicine during an investigation or other proceedings about a registered Chinese medicine practitioner.

[1] The *Code of conduct* can be found on the Board's website at www.ahpra.gov.au/Resources/Code-of-conduct/Shared-Code-of-conduct.aspx

[2] For the purpose of these guidelines, the term 'patient' is used to refer to the person receiving the treatment, care or healthcare services.

Patient health records for Chinese medicine practitioners

1. Responsibilities

Registered Chinese medicine practitioners have both professional and legal responsibilities to:

a. make and maintain adequate and accurate health records for each patient containing all the health information held by the practice about the patient

b. keep confidential the information collected and recorded about patients and keep, transfer, dispose of correctly and provide access to health records in accordance with the requirements of relevant state, territory and Australian laws relating to privacy and health records information, and

c. be familiar with the provisions of relevant state, territory and Australian laws relating to privacy and patient health records information.

2. General principles to be applied

a. Each patient should have an individual health record containing all the health information held by the practice about the patient.

b. Patient health records can be kept in either paper or electronic format.

c. The *Code of conduct* states that, if they have access, practitioners should check available electronic records, such as My Health Record, when taking a patient's history.

d. A patient health record should be made at the time of the patient consultation or as soon as possible after. This applies to all types of consultations, including those held after business hours, visits at home or elsewhere and virtual care i.e. telehealth (telephone and video-enabled), telemedicine and online prescribing consultations. Other information (such as test results, for example) should be included as soon as they become available.

e. Entries in a health record are expected to be made in chronological order and should identify the person making the entry.

f. Patient health records are expected to be legible and clear and of such a quality that another health practitioner could read the record and be sufficiently informed to make decisions about the continued safe care of the patient.[3]

g. If documents are scanned to the patient health record, such as external reports, the scanning needs to be completed as soon as possible and in a way that keeps the legibility of the original document and the chronology of the patient record.

h. All comments in the patient health record should be relevant to the care and/or management of the patient, respectful of the patient and objective.

i. Corrections can be made to a health record either at or after the time of original entry. The correction is to be initialled, dated and tracked by the practitioner and the original entry is to still be visible or digitally traceable.

j. Registered Chinese medicine practitioners are not to delegate responsibility for the accuracy of information in the patient health record to another person.

k. Registered Chinese medicine practitioners are permitted to use AI (artificial intelligence) tools in the process of making patient health records, provided that they comply with guidance on AI in healthcare, based on the responsibilities set out in the *Code of conduct*.[4]

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[3] The *Australian Dictionary of Clinical Abbreviations, Acronyms and Symbols* is a useful resource for practitioners about abbreviations. It may be helpful for individual practitioners to maintain a readily accessible glossary of common abbreviations that they use to help subsequent practitioners.

[4] *Meeting your professional obligations when using AI in healthcare* can be found on the Ahpra website at www.ahpra.gov.au/Resources.aspx

l. Patient health records are to be stored securely, protected from unauthorised access and safeguarded against loss or damage. For electronic records, there should be a process for secure transmission and a backup must be maintained.

m. Registered Chinese medicine practitioners are expected to recognise and facilitate a patient's right to access information contained in their patient health records. If a patient disputes the information then it should be removed, unless the practitioner disagrees. In the latter situation, the record should be maintained with a note stating the patient's beliefs about the accuracy of the record.

n. When formally requested by the patient, the transfer of health information is to be done promptly and securely, in accordance with the relevant state, territory and Australian laws relating to privacy and patient health records information. Patients should be advised of the location of patient health records on request. Practitioners should keep a record of any such requests.

3. Contents of a health record

a. The level of detail needed in a health record may vary according to the nature of the presenting condition and whether it is an initial or subsequent consultation. For example, in the case of subsequent visits for an ongoing condition, information recorded in earlier consultations need not be repeated, unless there are relevant changes. Progress details and treatment must be recorded clearly.

b. Any patient health record should contain the following information:

i. Sufficient and reasonable information to adequately identify and manage the patient, for example, full name, date of birth, gender identity and contact details, (and patient's parent or guardian where applicable).

ii. Up-to-date contact details of the person to be contacted in an emergency.

iii. The patient's explanation for seeking treatment and the presenting signs and symptoms, including a Western medicine diagnosis (if known).

iv. A current health summary, including but not limited to relevant past health and family history, known allergies, adverse drug reactions, current medications and, where clinically relevant, cultural background.

v. The date of any entry made and, if different from the date of the consultation or interaction, the date of each consultation and/or interaction.

vi. The time of consultation where there is more than one consultation or treatment on the same day.

vii. Relevant notes on obtaining informed consent (or its withdrawal) as per section 4.2 of the Board's *Code of conduct*.

viii. Any assessments and examinations carried out.

ix. Chinese medicine diagnosis and, where relevant, main complaint, relevant clinical impression, reasoning or interpretation.

x. Relevant diagnostic data and reports (for example, laboratory, imaging and other investigations) when available.

xi. Where relevant, estimates or quotations of fees.

xii. Any referrals to other healthcare providers or health services and relevant communication (written or verbal) with or about the patient, including telephone or electronic communication.

xiii. Information relating to any therapeutic intervention, advice, management plan or referral provided should include:

a. other treatments and/or therapies being used (where known)

b. Chinese medicine diagnosis, treatment principle(s), recommended treatment plan[5] and, where appropriate, expected process of review

c. procedures conducted, including details of all acupuncture points and needle manipulation method, particularly where a variation from a common procedure is applied

d. any medicine prescribed, administered or supplied for the patient (including formula name, ingredients, strength, quantity, dose, instructions for use, number of repeats and details of when started or stopped); the details are expected to comply with the Board's *Guidelines for safe Chinese herbal medicine practice*[6]

e. a record of any discussion(s) with a dispenser, for example to authorise substitution of herbs

f. relevant details of discussion of alternative treatment options

g. any unusual reactions, side effects that may follow treatment, or possible adverse events

h. the outcome of any therapeutic interventions and patient progress, and

i. details of anyone contributing to the Chinese medicine care and/or health record.

4. Retention and management of health records

a. Registered Chinese medicine practitioners are expected to comply with their own state and territory laws, as they may have specific requirements for the retention of records and other relevant matters.

b. Patients have a right to access their health information, and in some jurisdictions this right is enforceable under legislation. Such requests are most likely to arise when patients are moving address or seeking another opinion.

c. The requirements to keep and destroy patient health records vary between states and territories. Good practice involves being aware of the relevant laws and practices wherever the practitioner practices and complying with those standards.

d. In addition, practitioners who work in multi-practitioner clinics should be mindful of their contractual arrangements about retention and management of health records.

5. Language of health records

a. The primary purpose of the health record is to create a comprehensive and accurate record of the healthcare that has been provided in order to facilitate safe and effective care.

b. Records should be kept in English, with the exception of practitioners registered with English language conditions under grandparenting provisions.[7] These practitioners must make the following information in English, translated accurately, at the time of clinical consultation:

i. Sufficient and reasonable information to adequately identify and manage the patient, for example, full name, date of birth, gender identity and contact details, (and patient's parent or guardian where applicable).

ii. Emergency contact details.

iii. Chinese medicine diagnosis and, where relevant, main complaint, relevant clinical impression, reasoning or interpretation.

iv. Prescription of acupuncture and/or prescription of Chinese herbal medicines.

[5] If a patient refuses a proposed management plan, wholly or partially, the practitioner is expected to record what treatment has been accepted and what has been declined and the reasons if known.
[6] The *Guidelines for safe Chinese herbal medicine practice* can be found on the Board website at www.chinesemedicineboard.gov.au/Codes-Guidelines/Guidelines-for-safe-practice.aspx
[7] Transitional arrangements from 1 July 2012 to 30 June 2015 for registering existing Chinese medicine practitioners under section 303 of the National Law.

v. Any use of Chinese herbal medicine products in treatment provided.

vi. Any unusual reactions, side effects that may follow treatment, or possible adverse events.

c. If known, it is preferred that a Western medicine diagnosis be recorded in English, but this is not mandatory.

d. Prescriptions should be recorded as follows:

i. Acupuncture prescriptions can be recorded in English, pinyin or World Health Organisation numbering scheme for acupuncture points.

ii. Chinese herbal medicine prescriptions and the use of related products can be recorded in pinyin or with the English name to comply with the Board's *Guidelines for safe Chinese herbal medicine practice*.

e. Patient health records are expected to be drafted in such a way that another health practitioner could take over the care of the patient if necessary and in a manner that would allow another health practitioner to quickly identify pertinent information about the patient in the event of an emergency.

f. Chinese medicine practitioners should be aware that a request for access to records can come at any time, including from other health practitioners in an emergency, and it is the Chinese medicine practitioner's responsibility to respond to these requests without delay.

g. Health records in English may include profession-specific terminology (as do all health professions) and in Chinese medicine, may include terms written in pin yin (with acceptable addition of Chinese characters). In Chinese medicine, examples include terms such as *qi* or *chi*, names of syndromes such as *Bi Syndrome*, acupuncture point names such as *Zu san li* and number-based acupuncture points such as *ST36*.

h. Chinese medicine practitioners are also expected to comply with the nomenclature requirements in the Board's *Guidelines for safe Chinese herbal medicine practice*.

6. Translation of health records

a. Section 5b of this guideline sets out the minimum requirement of elements in health records for Chinese medicine practitioners with English language conditions on their registration to make in English, while previous versions of the guideline permitted this cohort to make full health records in a language other than English.[8]

b. Where records have been made in a language other than English in compliance with the current or a previous version of this guideline, the Board does not require these records to be translated unless and until the practitioner receives a request for these records to be translated.

c. The translation of records is the responsibility of the Chinese medicine practitioner, and the Chinese medicine practitioner is to be fully satisfied that the translation is comprehensive, accurately reflects the content of the original patient health record and follows this guideline.

7. Accounting records

a. While accounts are not part of the patient's health record, registered Chinese medicine practitioners also have a professional and legal responsibility to maintain accurate, legible and contemporary accounting records of each visit. This section is included in the guidelines as a reminder to practitioners of their obligations to keep proper financial records of services rendered to and charged to each patient.

b. An itemised tax invoice is to be created for each consultation/treatment which includes:

i. the patient's identity information[9]
ii. the date and types of each service

[8] This cohort were practitioners with English language requirements that were registered under grandparenting arrangements from 1 July 2012 to 30 June 2015 under section 303 of the National Law.
[9] See section 3.

iii. fees charged for all treatment(s) provided and all product(s) supplied
iv. the date of the payment/s if different from the date of service/s provided
v. date and number of the tax invoice issued
vi. name of the practitioner/s (as named on their registration) who provided the service/s, and
vii. address where the service was provided with contact telephone number.

8. Authority

These guidelines have been developed by the Chinese Medicine Board of Australia under section 39 of the Health Practitioner Regulation National Law, as in force in each state and territory (the National Law).

For more information

Visit www.chinesemedicineboard.gov.au

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Date of review: These guidelines will be reviewed within three to five years.