Lecture 14: Writing a Clinical Report

Course: Clinical Psychology
Module II: Clinical Writing Skills
Level: Third-Year Undergraduate (Clinical Psychology)
Duration: 90 Minutes

Learning Outcomes

By the end of this lecture, students will be able to:

- Define a clinical report and explain its role in clinical practice.
- Distinguish between a clinical report and a psychological assessment report.
- Identify the essential components of a clinical report.
- Write clear, concise, objective, and evidence-based clinical reports.
- Apply ethical and legal principles in clinical documentation.
- Produce professional clinical reports suitable for multidisciplinary healthcare settings.

Lecture Outline

1. Introduction
2. Definition of a Clinical Report
3. Importance of Clinical Reports
4. Types of Clinical Reports
5. Principles of Clinical Documentation
6. Standard Structure of a Clinical Report
7. Sample Clinical Report
8. Ethical and Legal Considerations
9. Common Errors
10. Classroom Activity
11. Summary

1. Introduction

Clinical documentation is an essential responsibility of every clinical psychologist. It provides a permanent record of the patient's psychological condition, interventions, progress, and treatment recommendations. One of the most frequently used forms of documentation is the **clinical report**.

Clinical reports ensure continuity of care by allowing healthcare professionals to share relevant information, monitor patient progress, and make informed clinical decisions. They also serve legal, educational, administrative, and research purposes.

Unlike psychological assessment reports, which focus primarily on diagnostic evaluation, clinical reports summarize the patient's overall clinical status and management over time.

2. Definition of a Clinical Report

A **clinical report** is a formal document that summarizes information collected during clinical evaluation, treatment, or follow-up. It records relevant observations, interventions, progress, and recommendations.

Definition

A clinical report is a structured professional document that records a patient's clinical history, assessment findings, treatment provided, progress, and recommendations to facilitate continuity of care and professional communication.

3. Importance of Clinical Reports

Clinical reports:

- Document patient care.
- Facilitate communication among healthcare professionals.
- Monitor treatment progress.
- Support diagnosis and treatment planning.
- Provide legal documentation.
- Assist research and quality assurance.
- Protect both patients and clinicians through accurate record-keeping.

4. Types of Clinical Reports

A. Initial Evaluation Report

Prepared after the first consultation and includes the presenting problem, history, and initial assessment.

B. Progress Report

Documents changes in symptoms, treatment response, and current functioning.

C. Discharge Report

Prepared when treatment ends, summarizing the course of care and recommendations for follow-up.

D. Consultation Report

Summarizes findings and recommendations following consultation with another professional.

E. Follow-up Report

Describes the patient's status after a period of treatment or monitoring.

5. Principles of Clinical Documentation

Effective clinical reports should be:

Accurate

Include only verified information.

Objective

Describe observable behavior and reported experiences without personal opinions.

Example

✔*The patient appeared tearful and reported persistent sadness.*

✘*The patient is emotionally weak.*

Clear

Use precise, professional language.

Concise

Include only clinically relevant information.

Organized

Present information in a logical sequence with clear headings.

Timely

Complete reports as soon as possible after the clinical encounter.

6. Standard Structure of a Clinical Report

A. Patient Identification

- Name
- Age
- Sex
- Date of birth
- Patient identification number (if applicable)

B. Date of Report

Record the date of the consultation or report preparation.

C. Referral Source

Identify who referred the patient.

Examples:

- Physician
- School counselor
- Self-referral
- Family member

D. Presenting Problem

Describe the main reason for consultation.

Example:

"The patient presented with persistent anxiety, insomnia, and academic difficulties."

E. Clinical History

Include relevant information regarding:

- Present illness
- Previous psychological treatment
- Medical history
- Family history
- Social history

F. Mental Status Examination (Brief Summary)

Summarize key observations regarding:

- Appearance
- Behavior
- Speech
- Mood and affect
- Thought processes
- Perception
- Cognition
- Insight
- Judgment

G. Clinical Formulation

Integrate information to explain the patient's difficulties using a biopsychosocial perspective.

Example:

"The patient's symptoms appear to be maintained by chronic academic stress, maladaptive coping strategies, and a family history of anxiety disorders."

H. Diagnosis (If Appropriate)

State the diagnosis using DSM-5-TR or ICD-11 terminology when sufficient evidence is available.

I. Intervention Provided

Describe treatment delivered during the session.

Examples:

- Clinical interview
- Psychoeducation
- Cognitive restructuring
- Relaxation training
- Crisis intervention

J. Progress

Describe changes since previous sessions.

Example:

"The patient reports reduced anxiety and improved sleep following relaxation training."

K. Recommendations

Examples:

- Continue psychotherapy.
- Refer for psychiatric evaluation.
- Schedule follow-up in two weeks.
- Encourage family support.

L. Signature

- Clinician's name
- Professional title

- Institution
- Date
- Registration number (if applicable)

7. Sample Clinical Report

Patient Information

Name: Ahmed Karim

Age: 23 years

Date: September 10, 2026

Presenting Problem

The patient presented with persistent anxiety, frequent panic attacks, and difficulty concentrating during university examinations.

Clinical History

Symptoms began approximately six months ago following increased academic demands. No previous psychiatric treatment was reported. Family history revealed anxiety disorders in the patient's mother.

Mental Status Examination

The patient was appropriately dressed and cooperative. Speech was normal in rate and volume. Mood was anxious with congruent affect. Thought processes were coherent. No hallucinations or delusions were reported. Insight and judgment were intact.

Clinical Formulation

The patient's symptoms are consistent with generalized anxiety related to academic stress and maladaptive coping strategies.

Diagnosis

Generalized Anxiety Disorder (DSM-5-TR)

Intervention

Psychoeducation regarding anxiety was provided, along with diaphragmatic breathing exercises and cognitive restructuring techniques.

Recommendations

Continue Cognitive Behavioral Therapy and schedule weekly follow-up sessions. Consider psychiatric consultation if symptoms persist.

8. Ethical and Legal Considerations

Clinical reports must adhere to professional ethical standards.

- Protect patient confidentiality.
- Obtain informed consent when required.
- Record factual information only.
- Avoid stigmatizing language.
- Maintain secure storage of clinical records.
- Correct errors transparently without altering original records.

9. Common Errors

Avoid:

- Writing subjective opinions.
- Using vague language.
- Omitting important clinical information.
- Copying previous reports without updating.
- Making unsupported diagnoses.
- Including irrelevant personal details.
- Using unexplained abbreviations.

Activity

Students receive a brief clinical vignette describing a patient with anxiety symptoms. Working individually, they prepare a one-page clinical report following the standard structure. Reports are exchanged for peer review using a checklist focusing on clarity, organization, objectivity, and completeness.

Summary

Clinical reports are essential documents that record patient assessment, treatment, progress, and recommendations. They facilitate communication among healthcare professionals and ensure continuity of care. Effective clinical reports are accurate, objective, concise, ethically sound, and clinically useful.

Key Terms

- Clinical Report
- Clinical Documentation
- Progress Note
- Clinical Formulation

- Mental Status Examination
- Treatment Plan
- Continuity of Care
- Professional Communication
- Confidentiality
- Clinical Record

Recommended Reading

- American Psychological Association. (2017). *Ethical Principles of Psychologists and Code of Conduct*. APA.
- Morrison, J. (2024). *The First Interview* (6th ed.). Guilford Press.
- Kaplan, H. I., Sadock, B. J., & Ruiz, P. (2023). *Kaplan & Sadock's Synopsis of Psychiatry* (12th ed.). Wolters Kluwer.
- American Psychiatric Association. (2022). *Diagnostic and Statistical Manual of Mental Disorders* (5th ed., Text Revision). American Psychiatric Association Publishing.

Conclusion

Clinical reports are indispensable tools in psychological practice. They document patient care, facilitate interdisciplinary communication, and support informed clinical decision-making. Mastering professional clinical documentation enhances the quality, safety, and continuity of psychological services.