Top Ten Items to Consider When Documenting Your Notes

1.	Compose notes as if you had to read them aloud in a courtroom—not to a jury of your peers, but to a jury of lay persons.
2.	Avoid writing that the patient "is noncompliant" (instead, try "is not taking the medication"), "refused treatment" (try "declined treatment"), or "failed the medication" (try "the medication failed").
3.	Convey hope in your assessment and plan, and list specific behavioral changes the patient can make to engage them in their recovery.
4.	Substitute more objective language for items that can be misinterpreted (eg, instead of "cry for help" or "suicidal gesture," write "a suicide attempt that was high in psychological significance but low in medical significance").
5.	Record all the sources of information you utilized to form your decisions, such as patient interview, nursing records, past visits, and collateral sources. This helps avoid allegations of hasty conclusions.
6.	Document the rationale behind your diagnosis, such as specific criteria, mental status exam, and associated signs.
7.	Avoid documenting identifying information about other people in the patient's life (eg, family, coworkers, etc).
8.	Use patient quotations where appropriate, especially when the patient's language is more effective than medical terminology in relating the moment.
9.	Discuss controversial areas with the patient in person before they read them in the note. Examples might include substance use disorders, personality disorders, delusional material, and secondary gain.
10.	Read notes aloud to see if unintended emotions are conveyed when the words are enunciated. Avoid exclamation points, asterisks, and other symbols that could convey negative emotions. When countertransference is strong, ask a peer to review your note before signing off.

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