Author: Attorney Dan A. Riegleman
N63 W23965 Main Street
Sussex, Wisconsin 53089
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PREPARING NARRATIVE REPORTS ON PATIENTS

Chiropractors may receive written requests from attorneys or others for a written report on a patient's condition. These reports are commonly referred to as "narrative reports" and can be provided to the requesting party if an appropriate authorization has been provided by your patient or the patient's legal representative. These reports are often relied upon in connection with personal injury litigation or medical insurance claims. The reports generally summarize the overall condition and care of the patient or will seek more specific opinions on critical aspects of care such as the "causation" of injuries or the long-term prognosis associated with any functional limitations or physical impairments. Your opinions in that report may be relied upon by an adjuster or, potentially, an insurance defense attorney or jury if the matter proceeds to litigation.

It is reasonable for you to request a fee in order to prepare something as important as this report. It is suggested that the doctor's charges are in some reasonable conformity to what their time is worth in actually preparing the report. It is not uncommon, at the time of this "White Paper", for such a report to be multiple pages and prebilled by chiropractors at rates of $250 to $1,000, depending upon the complexity of the report. Chiropractors are encouraged to obtain pre-payment of such fees before completing the narrative report.

The narrative report usually has certain contents which follow the "SOAP" concept of maintaining patient records. Those contents include:

1. Patient history; including details of the trauma associated with the accident or incident leading to chiropractic care.
2. Patient subjective complaints.
3. Doctor's objection exam findings.
4. "Diagnosis" or evaluation of the patient's condition; with particular emphasis on "causation" as to the influence of the trauma upon the patient's resulting condition as supported by the objective testing and findings. It should be noted that when addressing causation, the trauma of the relevant accident/incident can be "a proximate cause" in producing the patient's injuries or an "aggravation" of the patient's underlying or pre-existing condition(s).
5. Summary of the nature of chiropractic care provided; explaining why certain modalities were utilized, for how long, need for any referrals/adjunctive care you made, and the nature of progress towards restoration to "pre-accident condition."
6. Prognosis as it relates to the need for future care, frequency of care, cost of care, and any permanent physical limitations/residual problems on a long term basis (if known at the time you make the report).

Most, if not all, of the information in your report should be reliably sourced from your own patient notes or reliable records/reports from other providers involved in the patient's care. Many doctors will also solicit details on the accident/incident from their patient or through receiving an accident report.

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Finally, there is an important standard relating to any opinions which you provide in your report. Opinions on disputed issues can be provided by you to a "reasonable degree of chiropractic certainty or probability". Probability is regarded as "more likely than not". These opinions should be based upon your professional education, training, and experience with patients. Some doctors will also rely upon or reference reputable, research articles in support of their opinions; although it is not required. It is always a good practice to maintain some collection of this useful resource information which you may rely upon for future reference.

One last point: Do not be surprised if the party requesting information disputes or disparages your opinions. In that regard, it is often wise to inform, in advance, any patient involved in the matter that these reports can be forwarded to an adverse party and that there is no "guarantee" that such party will accept your opinions.