VETERINARY PRACTITIONERS BOARD

AUSTRALIAN CAPITAL TERRITORY

Record Keeping Guidelines

Content	ACT Veterinary Practitioners Board – Record Keeping Guidelines	Date
Policy	**APPROVED BY** ACT Veterinary Practitioners Board	December 2025

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1.0 Purpose

These Guidelines describe the standard of practice expected by the Board in the adherence to the ACT Veterinary Practitioners Code of Professional Conduct as it relates to records kept by veterinary practitioners in the ACT.

Professional standards must be adhered to in the delivery of all veterinary services and the responsibility for setting those standards rests with the ACT Veterinary Practitioners Board (the Board). The ACT Veterinary Practitioners Code of Professional Conduct (see below) sets out the basic requirements for a veterinary clinical record. Under the Code a veterinary practitioner must ensure that an appropriate and relevant record of any consultation, procedure or treatment is made as soon as is practicable and it must include any diagnostic tests, analysis and treatment.

2.0 Introduction/Context

It is the responsibility of veterinary practitioners to be conversant with the current version of these Guidelines.

The ACT Veterinary Practitioners Code of Professional Conduct outlines requirements of records as:

1. A veterinary practitioner must ensure that an appropriate and relevant, clear and succinct record of any consultation, procedure or treatment is made as soon as is practicable.
2. The record:
   a. must be legible and in sufficient detail to enable another veterinary practitioner to continue the treatment of the animal; and
   b. must include the results of any diagnostic tests, analysis and treatments.
3. If a record is altered, the alteration must be clearly identified and timestamped in the record as such.
4. A veterinary practitioner must ensure that all records of any consultation, procedure or treatment are retained for at least 4 years after they are made.

3.0 Guidelines

Veterinary clinical records are an essential tool in the practice of veterinary medicine and surgery. The records should contain the justification for patient care, including a medical history, differential diagnoses and serve as a means of communication between members of staff, and with others who may be consulted or to whom a case may be referred. For both clinical and legal purposes, they provide documentary evidence of the patient's ownership status, health status, care and treatment. They serve as a basis of review, study and evaluation of veterinary care rendered to the patient by the practice.

All veterinary practitioners are professionally obligated to ensure they maintain appropriate clinical records. This obligation is not restricted to those instances in which scheduled drugs are prescribed or dispensed but applies to all professional services provided by veterinary practitioners to their clients.

The Board would consider an appropriate and relevant record of any consultation, procedure or treatment should provide the following history data at a minimum:

- Date of consultation (date of record if different to date of consultation);
- Identification of all practitioners involved;
- Name of vet entering record;
- Client identification;
- Animal patient or herd identification;
- Medical history;

- Physical examination details;
- The date of consultation;
- Provisional and final diagnosis;
- Treatment given, dispensed or prescribed;
- Vaccination record; and
- Copy of any certificates issued.

Additionally, where relevant a clinical record should also include:

- Prognosis;
- Consultation progress notes;
- Discharge instructions;
- Radiography and ultrasonography records;
- Anaesthetic records;
- Laboratory reports;
- Hospitalisation treatment record;
- Advanced imaging reports, e.g. CT, MRI, Scintigraphy;
- Specialist reports;
- Surgical mortality record; and
- Necropsy reports.

In cases where schedule 8 (S8) drugs are administered or prescribed, the veterinary practitioner must ensure they comply with the requirements for recording the supply of the drugs in the practice S8 register as required under the Medicines, Poisons and Therapeutic Goods Act 2008 and other relevant legislation.

The use of artificial intelligence (AI) tools can be useful for veterinary practitioners to improve record keeping efficiencies. However, it is important that where such tools are used (for example, programs that record or transcribe consultations), informed consent is obtained from the client prior to it being use. This should involve explaining to the client how the tool works and how their personal information may be collected, used and stored. Importantly, veterinary practitioners must always review and edit the output of any program to ensure accuracy before it is included in the patient's clinical record.

3.1 Discussion

Irrespective of the species or number of animals treated, complete, well documented records provide evidence of practice protocols and treatments. Clear and succinct record keeping is essential to provide evidence of continuity of treatment between veterinary practitioners in situations where more than one veterinary practitioner attends to a case. Where S8 drugs are administered or prescribed, the production of good clinical records and accurate maintenance of the S8 registers demonstrates compliance. Clinical records should be able to stand alone in the event of an inquiry and be sufficient to justify the treatment and management of the particular case.

When investigating a complaint, the Board will request veterinary practitioners involved to provide the clinical records of the case. Where possible, these records should contain the premises name and contact details on top of the document.

The Board believes that the keeping of adequate clinical records is an essential component of professional conduct in contemporary veterinary practice. As a consequence, the failure to keep adequate and appropriate clinical records may result in the Board instituting disciplinary action against veterinary practitioners who have failed to maintain appropriate clinical records.

3.2 Synopsis

Clinical records should be:

- clear, succinct, accurate and complete;
- recorded at the time of, or as soon as possible following the provision of the veterinary service which includes but is not limited to consultations, provision of advice, examinations, surgical procedures and diagnostic examinations etc.;
- of sufficient detail to demonstrate the veterinary practitioner's assessment of, and treatment of a patient;
- in sufficient detail to enable a continuity of clinical assessment and treatment of a patient by another veterinary practitioner in the practice or if the animal is referred; and
- in compliance with relevant legislation.

Other points regarding clinical records include:

- annotations or amendments to clinical records:
    - for handwritten records, any subsequent annotations or entries, must include the date and the time of the annotation and be initialled by the veterinary practitioner;
    - for computer based records, subsequent annotations must be made as a separate record rather than amending the original clinical record;
- when a patient transfers to another veterinary practitioner, the primary veterinary practitioner should, when asked by a client, make available either a copy of the entire original medical record or a summary sufficient in detail to enable appropriate ongoing care of the case;
- this should, where appropriate, include other resources such as laboratory results and images;
- clinical records provided to the Board should be provided in their entirety; and
- computer based records - it is essential that adequate backups of the data are kept.

3.3 Code of Conduct for Veterinary Practitioners

Reference	Description
1	Veterinary Practice Veterinary Practitioner Code of Professional Conduct 2018

3.4 Other

Medicines, Poisons and Therapeutic Goods Act 2008