



Assessment and Management

Approved by Council: 2002 Reviewed and Updated: May 29, 2025

Introduction

Registrants must perform an assessment for each patient and must establish a management plan based on the assessment.

Assessment

- 1. The initial assessment must be recorded, and it must include pertinent information about the patient's history and relevant clinical findings.
- 2. A differential diagnosis must be documented, as well as a treatment plan with anticipated prognosis.
- 3. Required tests, referrals and/or consultations must be recorded.
- 4. The patient record must be reviewed periodically and amended where there is a change in health status.
- 5. Registrants must ensure that they review and adhere to the Records practice standard.

Management

- 1. Registrants must make every effort to ensure that treatment areas are private, secure and comfortable.
- 2. The condition, treatment plan and prognosis must be discussed with, and explained to, the patient.
- 3. No registrant shall treat or attempt to treat a problem or condition the registrant recognizes, or should have recognized, is beyond their experience, scope or competency.
- 4. No registrant shall provide treatment which they know, or should have known, would be harmful or which is inappropriate to meet the needs of the patient.
- 5. No registrant shall continue treatment of a patient where it is no longer indicated, or treatment has ceased to be effective.
- 6. Registrants must consult with and/or refer a patient to another health professional when the patient's condition is beyond the registrant's scope of practice, or where the referral/consultation is in the best interest of the patient.
- 7. The treatment plan must be reviewed periodically, and registrants must do appropriate follow-up.