

# RTS

## The Register of Trauma Specialists



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### **EVIDENCE BASED OUTCOMES**

#### **Notes for Guidance:**

- i) The enclosed *Patient/Client Outcomes* form should be treated as a master copy from which as many copies as required may be produced.  
(*N.B.* Replacement originals are available from RST on request).
- ii) The bulk of each patient/client form should be completed by the practitioner, leaving only the “*Percentage Improvement*” boxes, “*Overall Assessment of Entire Treatment*” box and “*Patient/Client Comments*” section to be completed by the client.  
(*N.B.* The list of problems may sometimes be quite long. It could, for example, include depression for x number of years, panic attacks, insomnia, phobic responses, low self-esteem, feelings of guilt etc.).
- iii) Before commencing the last session, each client should be asked to enter a score between **0% to 100% of how better they feel with regard to each and every presented problem and how they rate their overall improvement as a result of treatment**, in the appropriate boxes. They may also be asked to include any **thoughts or feelings about therapy itself, achievements etc** in the “*Comments*” section.
- iv) Obtaining this information has many benefits. The client may not always understand or recognise that there has been a change in them -- completing the form may help them to realise that their particular problem is greatly reduced, or even gone. A client may not wish to say that they still have a particular problem or concern -- for some, expressing it in writing will be easier. Also, should there be a low score to a particular item, the therapist will be aware before starting the final session, so that it can be addressed, rectified or resolved.
- v) You are also, in effect, monitoring your own performance. Consistent under-performance with clients requiring, for example, weight management, might persuade you to refer on to someone else, or perhaps attend a further course of instruction in the subject concerned.

***N.B.* This form is for the specific use of the practitioner ONLY and should be retained, along with all other patient/client records, in a completely secure place.**