GUIDE · DOCUMENTATION · VENDOR-NEUTRAL

Better notes start *before the software.*

How to feed any AI documentation tool material worth working with, and how to review what comes back. The drafting patterns adapt to many AI documentation tools; the narration and review habits may help with ambient scribes too, depending on the product. It depends on none of them.

WHAT THIS IS
The habits and prompt patterns that improve AI-drafted clinical documents: narrating the visit, structuring requests, and reviewing output in an order informed by one published validation study. Vendor-neutral on purpose. You own these habits; no subscription does.

HOW TO USE IT
Read the narration section with our published signposting guide (dx80group.com, Resource Library). Then adapt the prompt patterns to whatever tools your practice has approved. Rule one always applies: PHI only enters tools on your approved list with a BAA on file.

Habit one: narrate the visit

Ambient tools transcribe what is said aloud. The exam finding you noticed silently, the reasoning you did in your head, the plan you decided while typing: none of it reaches the draft. Signposting, narrating the what and the why aloud, is an established communication skill that makes you clearer to the patient. As a side effect it gives the tool more explicit material to work from. If a draft feels thin, first check whether the reasoning was actually said aloud. If it was and the note still misses it, the problem may be the tool, its configuration, the audio capture, or the workflow.

Narrate only what is clinically appropriate to say in the patient's presence. Do not verbalize sensitive, speculative, or third-party information, or details about another person, merely to feed the tool; follow the practice's procedures for minors, interpreters, caregivers, behavioral-health information, and anything learned outside the patient's presence.

Habit two: structure any drafting request

For non-ambient tools (drafting a letter, instructions, or a summary inside an approved system), a reliable request has four parts:

- **Role and audience:** who is writing, and who will read it. "A referral letter from a family physician to a gastroenterologist."
- **Context:** only the facts the document needs. Minimum necessary is good prompting, not just good HIPAA.
- **Constraints:** length, reading level, what to exclude. "Under 200 words, 8th-grade reading level, no medication changes."

- **Format:** the shape you want back. "Three short paragraphs: reason, history, question for the consultant."

Four patterns to adapt

Patient instructions: "Write after-visit instructions for [condition] for this plan: [plan]. 8th-grade reading level, under 250 words, warning signs that warrant a call, no new clinical content that is not in the plan I gave you."

Referral letter: "Draft a referral letter to [specialty]. Reason: [reason]. Relevant history: [history]. End with the specific question I want answered. Do not add findings I did not state."

Message reply: "Draft a reply to this patient message: [message]. Warm, plain language, under 120 words. The clinical answer is: [your answer]. Do not change the clinical answer."

Prior-auth first draft: "Draft a medical-necessity statement for [service] for a patient with [diagnosis]. Failed alternatives: [list]. Use only the clinical facts I provided, in formal payer language. Do not invent evidence, dates, failed therapies, policy criteria, or citations."

Before submission, the clinician or an authorized staff member must independently verify the payer's criteria and every factual representation in the statement. Unsupported or inaccurate prior-authorization statements carry billing and fraud risk beyond ordinary drafting errors.

The pattern behind the patterns: you supply the clinical judgment; the tool supplies sentences. Every prompt above ends with a fence around what the tool may not invent.

Habit three: review in error order

Independent validation research on ambient scribe drafts found omissions, things said but not written, to be the most frequent error type (Biro et al., JMIR 2025: errors in 31 of 44 draft notes across two products). So review in this order:

- **First, what is missing:** walk the visit in your head, check the draft against it. Missing findings, missing negatives, missing plan items.
- **Second, what is wrong:** numbers, laterality, medication names and doses, attribution of who said what.
- **Third, what was added:** boilerplate the tool inserted that you did not say or do. Delete it. Do not approve language you cannot verify; once signed or transmitted, the document is treated as your final documentation for the professional and organizational purposes that apply.

The 90-day habit

Whatever tools you use, re-measure. Run the Stage 2 time-study worksheet again 90 days after any documentation change. Keep what moved your numbers. Question what did not.

SOURCES · CHECK OUR WORK

Biro J, et al. Accuracy and Safety of AI-Enabled Scribe Technology. J Med Internet Res. 2025;27:e64993. jmir.org/2025/1/e64993

Rotenstein LS, et al. JAMA. 2026;335(16):1408-1417. doi:10.1001/jama.2026.2253

dX80. Narrate the visit: the signposting guide. dx80group.com Resource Library.