splose

Ask AI prompts for Physiotherapists

Welcome!
These prompts have been designed to give splose AI the context and instructions it needs to draft your most common clinical notes and reports. Each one is a strong starting point, designed to work straight away, but built to be adjusted to match your clinic's documentation style, the patients you see, and the way your team works.

Feel free to modify the structure, add your preferred headings, or change the level of detail to suit your needs.

Do your practitioners share patients?
If multiple practitioners at your clinic see the same patients and have permission to see each other's notes, you may want to scope certain prompts to that practitioner's notes only. For example, where a prompt reads "the most recent 3 previous progress notes for this patient, you can add "written by the current practitioner" to the end of the instruction to ensure the AI is only pulling in relevant notes as context.

Still like to write rough notes while transcribing the session?
If you like to add written notes (on the LHS of the page) while you're transcribing, ensure you've made it clear that those notes relate to the current session. This is particularly important if your preferred workflow is to copy your recent not into your new note – if you're mixing two pieces of context together, splose AI will get confused trying to determine what is related to today's session vs what you copied from your previous session.

Catch me up on this patient

I am a practitioner preparing for an upcoming physiotherapy session with this patient. Using the information available for this patient, create a concise pre-session briefing so I can review their history and plan before the session begins.

First, get patient details and include only clinically relevant information. Then get previous progress notes from the last 3 months. Then get appointments and support activities from the last 3 months and the next 2 weeks.

Using the retrieved information, write a structured pre-session briefing. Use bold headings and dot points. Fill each section using only what is explicitly documented:

Background: Diagnosis, presenting concerns, and any key clinical context relevant to understanding this patient.

Goals: List each goal documented for this patient. For each goal found, note any documented progress trend across recent progress notes (for example: improving, maintaining, plateauing, or not yet addressed). Also include whether any goal had been described as achieved in any of

the progress notes and the date it was recorded as such.

Last session: Summarise the most recent progress note. Include: the main focus of the session, how the patient presented, what was covered, and what was agreed at the end of the session including any homework, tasks, or strategies the patient committed to.

Upcoming: List the next scheduled appointment or support activity. Include the date, type, and any relevant context documented.

Important instructions:
- Use dot points only. Do not use paragraphs.
- Do not fabricate or assume any clinical information.
- Do not include clinical judgements or interpretations that are not explicitly stated in the notes.
- If a section has no relevant documented information, leave it blank rather than filling it with placeholder text.
- If this patient has no previous progress notes, summarise patient details only and note that no session history has been documented yet.
- Maximum length: one page

Running an initial assessment in a multidisciplinary clinic?
If your clinic shares patient notes across practitioners, consider adding a separate saved prompt with the following section added to it:

Other treating practitioners at this clinic
List any other disciplines currently seeing this patient at this clinic. For each, note the discipline, the treating practitioner's name if documented, and any clinically relevant context from their most recent notes that may inform today's session.

This can help you understand the full picture before an initial session. For example, if a patient is already seeing a dietitian or occupational therapist for related concerns that may

Write a Physiotherapy progress note

I am a Physiotherapist and I have just completed a session with a patient. I need to document today's session in a progress note.

First, review any content already written in the current progress note. Then the patient details. Then the most recent 3 previous progress notes for this patient. Then the most recent appointment details, and the next 2 upcoming booked appointments (if any exist).

Using the session transcript as the primary source of clinical content and all retrieved information, write a complete physiotherapy progress note for today's session using SOAP format with these bold headings: Subjective, Objective, Assessment, Plan.

Subjective: Document what the patient reported during today's session. Include their current symptoms, changes since the last session, pain levels, aggravating and easing factors, and any relevant personal or contextual information shared. Note any changes in function or daily activity reported by the patient.

Objective: Document objective clinical findings from today's session. Include relevant physical examination findings, range of motion, strength, functional measures, standardised outcome measure scores, and any special tests performed. Note changes from previous sessions where reported.

Assessment: Document a clinical analysis of the patient's presentation and progress based on today's session and their documented history. Note progress toward goals, response to treatment, patterns across recent sessions, and any emerging clinical concerns or changes to the clinical impression.

Plan: Document treatment delivered during today's session and agreed next steps. Include interventions performed and any reported response to each intervention, home exercise program instructions, referrals, and follow-up arrangements. Where upcoming appointments are available, use them to inform the timing and sequencing of planned follow-up. This section must contain only clinical content.

Content rules:
- Only include information explicitly present in the transcript, attachments, current note content, patient details, appointment details, or previous progress notes. Do not fabricate or infer clinical content not present in these sources. Silently discard anything that is not clinically relevant: personal reminders, uncertainties, admin notes, self-corrections, and anything written as a note to the practitioner rather than as a clinical observation. If something is unclear or uncertain, omit it.
- Write in plain, direct clinical language. Use short, active and simple sentences. Avoid formal report language, passive constructions, and clinical jargon where plain language conveys the same meaning.
- Refer to the patient by their preferred name (not "the patient").
- Format each section using concise dot points unless this practitioner's previous notes use paragraphs, in which case match that style.
- Output only the completed note. No step narration, no summary of what was done, no closing remarks.

Write a Physiotherapy initial assessment report

Tip – Directly attach supporting files to a prompt to improve the quality of your output
You can select them from Client files if they already exist or upload directly.

- Completed Service agreement PDF (or any other form that will serve as context)
- Completed Referral form PDF
- Referral documents
- Imaging reports
- Supporting documents

I am a Physiotherapist and I have just completed an initial assessment with a patient. I need to document today's session in an initial assessment report.

First, review any content already written in the current progress note. Then the patient details, including any referral information listed. Then the most recent appointment details, and the next 2 upcoming booked appointments (if any exist). If you have been provided with any referral letters, imaging reports, or supporting documents as attachments, use these as additional context.

Using the session transcript as the primary source of clinical content and all retrieved information, write a complete physiotherapy initial assessment. Use the following sections with bold headings. Omit any section entirely where the transcript and patient file contain no relevant information. Do not write placeholder text or note that information was not provided.

Reason for referral and presenting complaint: Why this patient has presented for physiotherapy. Include the referral source, mechanism of injury or onset of symptoms, primary complaint, and duration of symptoms.

Relevant history: Relevant medical, surgical, and medication history. Include previous episodes of the same condition, prior physiotherapy or allied health involvement, and any comorbidities relevant to this presentation.

Red flag screening: The outcome of red flag screening conducted during this assessment. If red flags were identified, document them clearly. If no red flags were identified, state this briefly.

Subjective report: The patient's self-reported experience of their condition. Include pain location, nature, and severity, aggravating and easing factors, 24-hour pattern, functional limitations, and the patient's own goals for therapy.

Objective findings: Physical examination findings from today's assessment. Include relevant range of motion, strength, neurological testing, special tests, functional measures, standardised outcome measure scores, and postural or movement observations. Present findings clearly with units and laterality where applicable.

Clinical impression and working diagnosis: A clinical interpretation of the assessment findings. Include the working diagnosis or clinical hypothesis and the key factors contributing to the patient's presentation.

Plan of care: Document treatment delivered during today's session and agreed next steps. Include interventions performed and any reported response to each intervention, home

exercise program instructions, referrals, and follow-up arrangements. Where upcoming appointments are available, use them to inform the timing and sequencing of planned follow-up. This section must contain only clinical content.

Content rules:
- Write in plain, direct clinical language appropriate to physiotherapy practice. Use short, active and simple sentences. Avoid formal report language, passive constructions, and clinical jargon where plain language conveys the same meaning.
- Only include information explicitly present in the transcript, attachments, current note content, patient details, or referral information. Do not fabricate or infer clinical content not present in these sources. Silently discard anything that is not clinically relevant. If something is unclear or uncertain, omit it.
- Refer to the patient by their preferred name (not "the patient").
- Format each section using concise dot points, except Clinical impression and working diagnosis which should be written in one or two complete sentences.
- Output only the completed note. No step narration, no summary of what was done, no closing remarks.

Initial assessments usually split over multiple appointments?
If you usually capture context in splose that will serve as additional context for the initial assessment you're completing (for example, you had a call with a parent before conducting the initial consult with the child present) and you wrote notes in separate progress note(s) ahead of the session, make these amendments to paragraphs 2 and 3:

First, review any content already written in the current progress notes. Then the patient details, including any referral information. Then the most recent appointment details, and the next 2 upcoming booked appointments if any exist. ***Then, review the last 3 progress notes as additional initial assessment information captured outside of this session.*** *If you have been provided with any intake forms, assessment documents, or background files as attachments, use these as additional context.*

Write a Physiotherapy third-party or insurer report

Tip – Directly attach supporting files to a prompt to improve the quality of your output
You can select them from Client files if they already exist or upload directly.

- Referral letters
- Referral documents
- Claim documents
- Imaging reports
- Supporting clinical documents

I am a Physiotherapist and I need to write third-party or insurer report for a patient.

First, review the patient details, including any referral or claim information listed. Then retrieve the last 3 months of progress notes for this patient. Then review any content already written in the current progress note. If you have been provided with any referral letters, imaging reports, claim documents, or supporting clinical information as attachments, use these as the primary source of clinical content. If a transcript is available, use it as additional context.

Using all retrieved information and any attachments, write a complete physiotherapy funding or third-party report. Use the following sections with bold headings. Omit any section entirely where no relevant information is available. Do not write placeholder text or note that information was not provided.

Client and claim details: The patient's full name, date of birth, claim or funding reference number, insurer or funding body, and treating physiotherapist details where documented in the patient file.

Reason for report: The purpose of this report, the funding or claim context, and the period of treatment being reported on.

Summary of presentation: A brief summary of the patient's diagnosis or presenting condition, mechanism of injury or onset, and relevant medical history relevant to the claim or funding request.

Treatment summary: The physiotherapy treatment provided across the reporting period, including total sessions attended, primary interventions delivered, and the clinical rationale for treatment.

Progress and outcomes: The patient's progress across the reporting period. Include objective outcome measure scores at baseline and most recent assessment where documented. Note functional improvements, areas of ongoing difficulty, and response to treatment.

Current status: The patient's current functional status and capacity at the time of this report. Include relevant objective findings, pain levels, functional limitations, and capacity for work or daily activities where documented.

Recommendations: Recommended ongoing treatment, frequency, duration, and goals. Include any referrals to other services, workplace modifications, or other recommendations relevant to the claim or funding body. Each recommendation should be linked to a specific clinical finding documented in this report.

Content rules:
- Write in formal, objective clinical language appropriate to a medico-legal or funding report context. Use third person throughout. Use paragraphs rather than dot points, except under Progress and outcomes and Current status where structured presentation of objective measures improves clarity.
- Only include information explicitly present in the attachments, retrieved progress notes, patient details, or current note content. Do not fabricate or infer clinical content not present in these sources. Do not include opinions, prognoses, or recommendations that are not directly supported by documented findings.
- Where outcome measure scores are available, present them with the measure name, date, and score clearly stated.
- Refer to the patient by their preferred name (not "the patient").
- Output only the completed report. No step narration, no summary of what was done, no closing remarks.

Write an NDIS End of Plan report

Tip – Directly attach supporting files to a prompt to improve the quality of your output
You can select them from Client files if they already exist or upload directly.

- The participant's NDIS plan
- Assessment results
- Supporting documents
- Related completed forms

I am a Physiotherapist and I need to write an NDIS end of plan report for a patient.

First, review the patient details, including any NDIS plan information listed. If you have been provided with the participant's NDIS plan, assessment results, or supporting documents as attachments, use these as additional context. Then, retrieve progress notes only finalised during the current NDIS plan period, using the plan start and end dates to scope the retrieval. Then review any content already written in the current progress note.

Using all retrieved information and any attachments, write a complete NDIS physiotherapy end of plan report. Use the following sections with bold headings. Omit any section entirely where no relevant information is available. Do not write placeholder text or note that information was not provided.

Participant and plan details: The participant's full name, date of birth, NDIS number, plan period dates, and funding management type where documented.

Reason for report: The purpose of this report and the physiotherapy services delivered under this plan period.

Background: A brief summary of the participant's primary diagnosis, relevant medical history, and functional presentation at the start of this plan period.

Service details: The type of physiotherapy service provided, the therapeutic approach used, the duration and frequency of supports, the goals worked toward, and the intended outcome of delivering those supports.

Baseline functional capacity: The participant's functional capacity at the start of this plan period. Document the assessment measures used to quantify baseline functional capacity, including the measure name, date, and score where recorded. This section establishes the starting point against which progress is measured.

Goals and progress: Each NDIS goal documented for this participant presented as a heading, followed by a summary of progress toward that goal across the plan period. For each goal include: evidence of progress drawn from progress notes, the therapy outcomes achieved and how they relate to the NDIS goal, any outcome measure scores at baseline and most recent assessment to demonstrate change, and a clear statement of whether the goal has been achieved, is progressing, is partially progressing, or has not yet been addressed. Where a goal has not been addressed, note any documented reason.

Current functional status: The participant's current level of physical function at the end of this plan period, based on the most recent progress notes and outcome measures. Where baseline outcome measures were documented, present current scores alongside baseline scores to demonstrate change.

Barriers to progress: Any factors that limited progress during this plan period, including attendance, health events, changes in the participant's circumstances, or gaps in service. Where barriers were identified, describe how they were addressed or how the therapy approach was adjusted in response.

Risks: Any risks to the participant identified during this plan period while delivering NDIS supports. Describe what the risks were and how they were addressed. If no risks were identified, omit this section.

Additional supports: Any informal, community, or mainstream supports that could assist the participant in working toward their goals, and any referrals or recommendations to other services made during this plan period.

Recommendations for next plan period: Recommended physiotherapy supports, frequency, goals, and any assistive technology or equipment needs for the next NDIS plan period. Address the NDIS reasonable and necessary criteria for each recommendation: the support is related to the participant's disability, it is likely to be effective, and it takes into account what can reasonably be provided through informal supports or other services. Each recommendation should be linked to a specific finding documented in this report.

Content rules:
- Write in formal, objective clinical language appropriate to an NDIS report. Use third person throughout. Use paragraphs rather than dot points, except under Goals and progress where structured goal-by-goal presentation is required.
- Only include information explicitly present in the retrieved progress notes, attachments, patient details, or current note content. Do not fabricate or infer clinical content not present in these sources. Do not summarise or interpret beyond what is explicitly documented across the plan period.
- Where outcome measure scores are available, present them with the measure name, date, and score clearly stated.
- Refer to the participant by their preferred name, not "the patient."
- Output only the completed report. No step narration, no summary of what was done, no closing remarks.

Write a NDIS letter of supports for AT or home modifications

Tip – Directly attach supporting files to a prompt to improve the quality of your output
You can select them from Client files if they already exist or upload directly.

- The participants NDIS plan
- Assessment findings
- Supplier quotes
- Equipment specifications
- Supporting clinical documents
- Related completed forms

I am a Physiotherapist and I need to write an NDIS letter of support for a participant.

First, review the patient details, including any NDIS information listed. Then the most recent 5 previous progress notes for this patient. Then any content already written in the current progress note. If you have been provided with any AT trial documentation, assessment findings, supplier quotes, equipment specifications, or supporting clinical documents as attachments, use these as the primary source of clinical content.

Using all retrieved information and any attachments, write a complete NDIS letter of support. Use the following sections with bold headings. Omit any section entirely where no relevant information is available. Do not write placeholder text or note that information was not provided.

Participant details: The participant's full name, date of birth, NDIS number, and plan details where documented.

Purpose of this letter: The specific item or modification this letter is supporting. State the AT cost category (low-cost, mid-cost, or high-cost) and the relevant NDIS approval process that applies. Include the approved NDIS funding amount and item specifications where documented in the patient file or attachments.

Current functional status and clinical presentation: The participant's relevant functional limitations and clinical presentation as documented in the patient file and progress notes. Focus on the functional impacts that directly relate to the need for this item or modification.

Clinical rationale: Why this specific item or modification is required. Link each clinical reason directly to a documented functional limitation or risk. Explain why this item is the most appropriate solution for this participant's needs.

Trial outcomes: Where a trial of the item or modification has been completed, document the trial date, what was trialled, the participant's response, and the clinical outcomes of the trial. Include any objective measures or functional observations recorded during the trial.

Alternatives considered: Any alternative items, modifications, or approaches that were considered and the clinical reasons they were not recommended for this participant.

Assessment and training: Confirmation that a clinical assessment was completed by a qualified physiotherapist and that the item or modification was assessed as appropriate for this

participant's needs. Where training in the safe and effective use of the item has been completed, document this. Where training is yet to be provided, state that this is a clinical obligation that will be fulfilled upon delivery and that the treating physiotherapist will confirm safe use and make any required adjustments.

NDIS justification: A statement addressing the NDIS reasonable and necessary criteria as they apply to this request. Address each of the following: the item is related to the participant's disability; the item is not a day-to-day living cost unrelated to the disability; the item is likely to be effective for this participant based on documented trial outcomes or clinical evidence; and the item takes into account what can reasonably be provided through informal supports, other funding sources, or mainstream services.

Content rules:
- Write in formal, objective clinical language suitable for submission to the NDIA. Use third person throughout. Use paragraphs rather than dot points.
- Only include information explicitly present in the attachments, retrieved progress notes, patient details, or current note content. Do not fabricate or infer clinical content not present in these sources. Do not include claims about trial outcomes, assessment dates, equipment specifications, or quotes that are not documented.
- Refer to the participant by their preferred name, not "the patient."
- Output only the completed letter. No step narration, no summary of what was done, no closing remarks.

Write a Physiotherapy handover or discharge summary

Tip – Directly attach supporting files to a prompt to improve the quality of your output
You can select them from Client files if they already exist or upload directly.

- Previous handover or discharge summaries
- Assessment results
- Review reports
- Supporting documents
- Referral PDFs or forms

I am a Physiotherapist and I need to write a handover and discharge summary for a patient.

First, review the patient details, including any referral information listed. Then retrieve the last 3 months of progress notes on file for this patient. Then review any content already written in the current progress note. If you have been provided with any previous handover or discharge summaries, assessment results, referral information or supporting documents as attachments, use these as additional context.

Using all retrieved information and any attachments, write a complete physiotherapy handover and discharge summary. Use the following sections with bold headings. Omit any section entirely where no relevant information is available. Do not write placeholder text or note that information was not provided.

Patient overview: A brief summary of the patient's background, primary diagnosis or presenting complaint, and reason for referral to physiotherapy.

Social and contextual information: Any social, family, or legal context that affects how care is delivered or how the patient is communicated with. This includes custody arrangements, court orders, communication restrictions, safety concerns regarding specific contacts, and any other contextual factors the receiving provider must be aware of before engaging with the patient or their support network. Include only what is explicitly documented in the provided context for this patient.

Services received: The physiotherapy services provided to this patient, including the approximate duration of service, total number of sessions attended, and the primary areas of treatment focus across the service period. Output for this section must return as a list containing:

Services commenced: [date of the first appointment booked for the patient (current practitioner only) eg. “November 2025”]
Services ended: [date of the last appointment on record booked for the patient (current practitioner only) eg. “March 2026”]
Duration: [the number of months between the first appointment and the last appointment listed above eg. “10 months”]
Sessions attended: [the total number of appointments (current practitioner) eg. “18 sessions”]
Frequency: [eg. “weekly”, “fortnightly”, “monthly”]
Setting: [based on what was documented in the patient’s progress note history, list the settings where sessions were held with the patient eg. “clinic based sessions with two home visits conducted in December 2025 and Febuary 2026”]
Primary areas of therapy focus: [based on what was documented in the patient’s progress note history, list the primary areas of documended focus areas eg. “lumbar spine rehabilitation, graduated return to work program, strength and conditioning, and manual therapy for pain management”]

Goals: The therapy goals worked on during the service period. For each goal, provide a brief statement of whether it was achieved, partially achieved, or not achieved, with supporting evidence from the progress notes where available.

Progress and outcomes: A summary of the patient's overall progress and functional outcomes across the service period. Note key improvements, areas of ongoing difficulty, changes in outcome measure scores where documented, and any significant changes in functional status.

Safety considerations: Any safety factors relevant to the next provider or carer. Include documented precautions, contraindications, fall risk, weight-bearing restrictions, movement precautions, or any other clinical safety information documented in the patient file.

Communication preferences: The patient's documented communication preferences, including language, literacy considerations, and any adjustments required for effective communication.

Funding: Remaining NDIS funding or third-party claim details where documented in the patient file and relevant to the handover.

Recommendations: Recommended next steps, ongoing supports, home exercise program continuation, therapy priorities, or referrals for the receiving provider. Each recommendation should be grounded in the clinical picture documented in this summary.

Content rules:
- Write in plain, direct clinical language. Use short, active and simple sentences. Avoid formal report language, passive constructions, and clinical jargon where plain language conveys the same meaning.

- Only include information explicitly present in the retrieved progress notes, attachments, patient details, or current note content. Do not fabricate or infer clinical content not present in these sources. Silently discard anything that is not clinically relevant. If something is unclear or uncertain, omit it.
- The Social and contextual information, Communication preferences and Funding sections are particularly susceptible to assumed or placeholder content. If nothing is explicitly documented for either, omit them entirely.
- Refer to the patient by their preferred name (not "the patient").
- Format each section using concise dot points.
- Output only the completed summary. No step narration, no summary of what was done, no closing remarks.