

ScribePT Context Best Practices

CLINICAL PRACTICE GUIDE

Optimizing AI Input for Rapid, High-Quality Clinical Documentation

Core Principle: In ScribePT, a "Context" is any information you supply to the AI (audio, written notes, prior encounters, or intake data). High-quality context yields accurate, audit-ready clinical notes.

TYPE 1 Audio Encounters

1. Dictated vs. Ambient:

- **Dictation:** Speak structured findings post-session for concise notes.
- **Ambient:** Record natural therapist-patient dialogue live.

2. Speak Measurements Aloud:

- Call out objective data: ROM, strength, pain scale (0–10), & billing units.
- "ScribePT hears what you say, not what you see."

3. Audio Quality:

- Ensure clear mic placement & grant persistent browser mic permissions.

TYPE 2 Written & Tab Data

1. Therapist Comments:

- Add shorthand scratch notes to supply missing visual cues or clinical rationale.

2. Active Tab Capture:

- Use "Pull info from active tab" to grab patient details from open EMR tabs.

3. Combining Contexts:

- Combine audio + written comments for complex evaluations or multi-segment treatments.

TYPE 3 Historical & Referrals

1. Previous Encounters:

- Select prior evaluations or daily notes to maintain goal progression context.

2. Intake & Referrals:

- Include medical history, surgical dates, or physician prescription data.

3. Updating Context:

- Always click **UPDATE ENCOUNTER** after adding or editing context items.

🎯 OBJECTIVE VS. SUBJECTIVE CONTEXT

- **DO:** State specific values — "Left shoulder flexion is 142° with mild pain at end range."
- **DON'T:** Use vague generalities — "Shoulder ROM improved slightly today."
- **Clarity First:** More objective detail = higher accuracy in SOAP note generation.

⚠️ ESSENTIAL CONTEXT WORKFLOW RULES

- **At Least 1 Context Required:** You must attach at least one context item before submitting an encounter.
- **Disable Auto-Sleep:** Prevent device sleep during ambient recording to avoid audio dropouts.
- **Verify Output:** Always review the AI note against your context before pasting into your EMR.

💡 Quick Context Reference Matrix

Initial Evaluation

Combine **Audio Recording** + **Intake Form** + **Physician Referral** for comprehensive baseline SOAP notes.

Daily Visit / Routine

Use **Ambient Recording** or **Dictation** + quick **Written Comments** for treatment interventions.

Progress Note / Re-Eval

Pull **Past Evaluation Note** + **Dictated Re-Assessment Data** to highlight measurable goal progress.

Have Questions? Submit a support ticket at scribept.com/ticket

Support Library: scribept.com/support