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Organising Medical Information for a Family Member

A practical guide to keeping medications, medical records, appointments and important health information organised

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Produced by the team at OURO

Care coordination made simple.

ourocare.com

THE SHORT ANSWER

How do I organise medical records for a family member?

Start by creating one organised system that holds a quick-reference health summary, a current medication list, important contacts, appointment information and key medical documents. Keep the information current, and make sure the person you're caring for keeps appropriate control over who can access and share it.

> **WHERE TO BEGIN**
>
> You don't need to organise every piece of medical history before you start. Begin with the information you're most likely to need during an appointment, a medication change, or an unexpected hospital visit.

Start with these 8 things

1. Current medications
2. Allergies
3. Major diagnoses and conditions
4. GP and specialists
5. Important contacts
6. Recent appointments
7. Current care plans
8. Important reports and documents

Most families build this gradually — often after a hospital stay, a new diagnosis, or the moment it becomes clear that no single doctor holds the whole picture. That's completely normal. The rest of this guide walks through each piece in more detail, and page 15 pulls it all together into one checklist.

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02 — HOW TO USE THIS GUIDE

The family medical information system

This guide is designed to help you build a practical system — not a perfect medical archive. You don't need to record everything. You need to reliably find the things that matter, when they matter.

KEEP IT CURRENT

Update information as things change, not in one big annual clean-up.

KEEP IT FINDABLE

A system only works if you can find what you need in a hurry.

KEEP IT APPROPRIATELY SHARED

The right people should have access to the right information.

The three-layer system

Family medical information naturally falls into three layers. Thinking about it this way makes it far easier to organise — and far easier to find what you need under pressure.

1 · The Quick View

The small amount of information you may need immediately — medications, allergies, conditions, emergency contacts.

↓

2 · The Working Record

What you need to manage ongoing care — appointments, care plans, specialists, recent changes.

↓

3 · The Source Documents

The original reports, letters, results and discharge summaries that support the record above.

03 — THE MASTER LIST

What medical information should I keep for a family member?

DIRECT ANSWER

A useful record covers six areas: identity and emergency details, health background, medications, the care team, current care activity, and supporting documents. Not every category will apply to every family — use what's relevant.

IDENTITY & EMERGENCY

- Full name and date of birth
- Emergency contact
- Medicare details, where appropriate
- Preferred hospital, where relevant

HEALTH

- Major diagnoses
- Allergies
- Relevant medical history
- Current health concerns

MEDICATIONS

- Name, strength, dose, frequency
- Reason for use, where known
- Prescribing clinician
- Pharmacy

CARE TEAM

- GP
- Specialists
- Allied health professionals
- Pharmacy and other key services

CURRENT CARE

- Care plans and treatment plans
- Upcoming appointments
- Follow-up actions

DOCUMENTS

- Pathology and imaging
- Specialist letters
- Hospital discharge summaries

This is an organising tool, not a clinical one. It helps you keep track of information — it does not ask you to interpret it.

04 — MEDICATIONS

How do I keep track of my family member's medications?

DIRECT ANSWER

Keep one current medication list — not several. Record the medication, dose, timing, reason, prescriber and pharmacy, and update it the moment anything changes, rather than waiting to "get around to it".

Medication	Dose / strength	When	Why it's taken	Prescriber	Notes

Include prescription medicines, over-the-counter medicines and relevant supplements — all of them matter to a full picture, and all of them are worth mentioning to a prescriber or pharmacist.

GOOD TO KNOW

Many pharmacies can print a current dispensing history or medicines list on request, which is a useful starting point if you're building a list for the first time. It's worth checking this against what's actually being taken, since not everything prescribed is necessarily still in use.

Update the list whenever:

- ☐ A medication starts
- ☐ A medication stops
- ☐ A dose changes
- ☐ Timing changes
- ☐ A prescriber changes something
- ☐ A medication is replaced



Medication changes should always be confirmed with the relevant healthcare professional. This guide is about keeping the list organised — not about deciding what should be on it.

05 — RECORDS AND DOCUMENTS

What medical records should I keep?

DIRECT ANSWER

Sort documents into current and historical, rather than keeping everything in one undifferentiated pile. This one distinction is what keeps a growing folder usable instead of overwhelming.

ESSENTIAL / CURRENT

- Current care plans
- Current medication list
- Current specialist information
- Recent hospital discharge summaries
- Important recent reports
- Emergency information

REFERENCE

- Previous specialist reports
- Significant historical diagnoses
- Important imaging
- Significant pathology
- Relevant hospital records

ARCHIVE

- Superseded medication lists
- Old appointment notes
- Historical documents no longer actively needed

Don't delete important records simply because they're old — a specialist may ask about history from years earlier. Instead, separate **current** from **historical**, so the things you reach for often stay easy to find.

Paper, digital, or both?

Either can work well. A physical folder is easy to grab on the way out the door; a digital folder is easier to search and share with family members who live elsewhere. Many families end up using both — a slim physical folder for the essentials, and a digital copy of everything as a backup.

> *"Did the hospital send the discharge summary?"*

06 — THE CARE TEAM

How do I organise my family member's doctors and appointments?

Build a simple picture of everyone involved in care, centred on the person receiving it.

GP	SPECIALIST	PHARMACY
ALLIED HEALTH	HOSPITAL	OTHER SERVICES

For each provider, it's worth recording their name, organisation, specialty, phone number, location, next appointment and any important follow-up.

Appointment tracker

Date	Provider	Purpose	Key questions	Outcome	Follow-up	Responsible

Recording "responsible person" matters most in families where more than one person shares the caring role — see page 14.

> *"I can't remember which specialist said that."*

After the appointment

The few minutes right after an appointment are often when the most useful details slip away. Jotting down the outcome and any follow-up — even briefly — while it's fresh makes the next appointment, and the next family member who needs to know, much easier to bring up to speed.

GOOD TO KNOW

Specialists often send a letter back to the GP after a consultation. Asking whether a copy can be shared with you (with appropriate permission) is a simple way to keep the working record accurate without relying on memory.

07 — TEST RESULTS & REPORTS

How do I keep track of test results and medical reports?

DIRECT ANSWER

Track results the same way you'd track a task: was it done, was it reviewed, and what happens next. A result being available is not the same as a result being acted on.

Test performed → **Result available** → **Reviewed with clinician** →
Action / follow-up → **Recorded**

Date	Test / report	Provider	Result received?	Discussion required?	Follow-up

Don't assume a result being available means no action is needed. Follow up with the relevant healthcare professional about what it means and whether anything needs to happen next. This guide is about organisation — not interpretation.

Pathology results (like blood and urine tests) and diagnostic imaging reports are increasingly available to view online soon after they're uploaded — sometimes immediately, sometimes after a short delay. That makes it easier to know a result exists. It doesn't replace the conversation about what it means, which is why the "discussion required" column matters as much as the "received" one.

08 — MY HEALTH RECORD

What is My Health Record, and should I use it?

DIRECT ANSWER

My Health Record is the Australian Government's secure national digital health record. It can hold a genuinely useful summary of medicines, allergies, pathology, imaging and hospital discharge information — but it works best alongside a family system, not instead of one.

My Health Record may contain, where uploaded by a healthcare provider: medicines, allergies, pathology results, diagnostic imaging reports, hospital discharge summaries, immunisation information, and other clinical documents.[1]

Australia's health system is moving toward more automatic sharing of this information. From July 2026, pathology and diagnostic imaging reports are required to be uploaded to My Health Record by default in most cases, and the government has flagged medicines information from online prescribing services as the next category to be added.[2] Even so, uploading isn't universal — some documents are excluded, delayed, or never uploaded at all, so it's worth checking rather than assuming.

My Health Record

Government digital health record

- Clinical summary from providers
- Pathology & imaging reports
- Discharge summaries
- Medicines & immunisations

Your family care system

Practical coordination layer

- Appointments & tasks
- Questions for clinicians
- Practical responsibilities
- Family updates & documents

These aren't competing systems — use the appropriate one for the appropriate purpose. My Health Record holds clinical information; a family system helps you organise, act on and share it day to day.

GOOD TO KNOW

A small number of sensitive categories — including HIV status and certain notifiable conditions in some states — require the person's specific consent before they can be uploaded to My Health Record. This is a reminder that My Health Record reflects what's been uploaded and consented to, not automatically everything about someone's health.

1–2. Australian Government Department of Health, Disability and Ageing; Australian Digital Health Agency. See Sources & References, p.18.

09 — PRIVACY & CONSENT

Can I access my family member's medical records?

DIRECT ANSWER

Not automatically. Being someone's child, spouse, sibling, parent or carer doesn't, by itself, grant legal access to their health information. Access generally depends on their consent, an authorised representative arrangement, or another form of legal authority.

Being someone's carer and being legally authorised to access all of their health information are not necessarily the same thing. Healthcare providers and My Health Record both generally require the person's consent, or evidence that you're authorised to act on their behalf, before sharing their health information with you.[3]

On My Health Record specifically, there are two distinct roles: a **nominated representative** is invited by the person to view or help manage their record, with an access level the person controls; an **authorised representative** has complete access and must manage the record in line with that person's will and preferences — this role generally applies when someone cannot manage their own record.[4]

Before sharing, ask:

- ☐ Does the person want this person to have access?
- ☐ Is there appropriate authority in place?
- ☐ Does the recipient need all of the information, or only part of it?
- ☐ Is the information being shared securely?
- ☐ Is the information current?

OURO MICRO-TIP Talk about information-sharing preferences before a crisis, if possible. Knowing who the person wants involved can make difficult situations much easier.

3–4. Office of the Australian Information Commissioner; Australian Digital Health Agency. This is general information, not legal advice — see disclaimer, p.18.

10 — BEING PREPARED

What should I have ready for an appointment — or an emergency?

The 5-minute appointment prep

- ☐ Current medication list
- ☐ Allergies
- ☐ Major diagnoses / conditions
- ☐ Recent changes or symptoms
- ☐ Recent test results, where relevant
- ☐ Questions to ask
- ☐ Current care plan
- ☐ Follow-up from last visit

What should I have ready in an emergency?

EMERGENCY INFORMATION

NAME	DATE OF BIRTH
KEY ALLERGIES	CURRENT MEDICATIONS
MAJOR CONDITIONS	KEY CONTACT
GP	SPECIALIST

Keep only what's genuinely useful in an emergency summary, and store it appropriately rather than somewhere easily accessible to anyone.

> *"Where do I find all of this if we end up in hospital tonight?"*

That's exactly the question an emergency card is designed to answer. Keep a copy somewhere genuinely quick to reach — on your phone, in a wallet, or with whoever is most likely to be there in an emergency — rather than buried in a folder you'd need time to search.

11 — STAYING CURRENT

How do I keep medical information up to date?

This is one of the biggest practical problems in family care — information doesn't stay accurate on its own. A simple trigger system solves most of it.

The update trigger system

When this happens…	…do this
Medication changed	Update medication list
New diagnosis	Update health summary
New specialist	Update care team
Appointment completed	Record outcome / follow-up
New report	File it and record it
Care plan changed	Replace the current version
Hospital visit	Review everything after discharge

Change happens → **Update the master record** → **Check who needs to know** → **Archive superseded information**

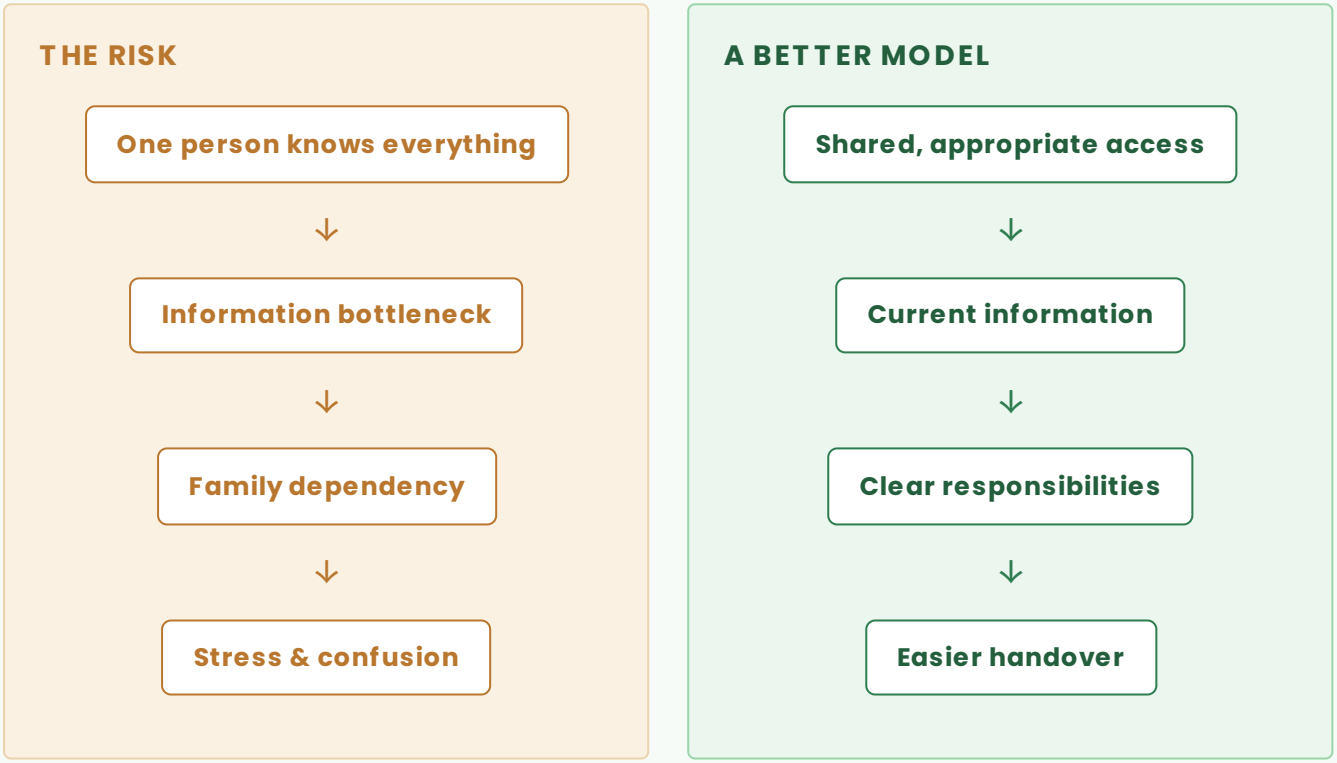
> *"What did the GP say at the last appointment?"*

A trigger system works because it removes the guesswork about when to update things. You don't need to remember to "do a review" — you just need to notice when one of these seven things happens, and act on it in the moment.

12 — THE HANDOVER PROBLEM

What happens when one family member is doing all the organising?

Someone in almost every family ends up becoming **"the person who knows everything"** — the medication changes, the doctor names, the test results, what happened at hospital, what needs to happen next. It works, until that person is unavailable, sick, or simply asleep at 2am — and everyone else is starting from zero.



"Shared" doesn't mean "everyone sees everything." It means the right people can access the information they need, with the appropriate permission — so care doesn't depend entirely on one person being available.

> *"Does my sister know the medication changed?"*

Small, practical habits close this gap without requiring a big system overhaul: a shared note that's actually kept current, a quick message after every appointment, or a regular five-minute call with whoever else is involved. The goal isn't a perfect record everyone reads constantly — it's making sure no single person is the only path to important information.

13 — PUT IT ALL TOGETHER

Family medical information checklist

PERSON

- [ ] Full name
- [ ] Date of birth
- [ ] Emergency contact
- [ ] Relevant Medicare info

HEALTH

- [ ] Major conditions
- [ ] Allergies
- [ ] Important history

MEDICATIONS

- [ ] Current list
- [ ] Doses / strengths
- [ ] Timing
- [ ] Prescriber & pharmacy

CARE TEAM

- [ ] GP
- [ ] Specialists
- [ ] Allied health
- [ ] Other key providers

APPOINTMENTS

- [ ] Upcoming appointments
- [ ] Questions to ask
- [ ] Follow-up actions

DOCUMENTS

- [ ] Care plans
- [ ] Specialist reports
- [ ] Discharge information
- [ ] Pathology & imaging

SHARING

- [ ] Permission understood
- [ ] Right people identified
- [ ] Preferences known

MAINTENANCE

- [ ] Review after med changes
- [ ] Review after hospital visits
- [ ] Archive outdated info

You don't need to complete everything today. Start with the information you're most likely to need next.

14 — THE BIGGER PICTURE

The goal isn't to remember everything.

The goal is to make sure the important information doesn't live in only one person's head.

Families often begin with screenshots, paper folders, text messages, email threads, notes apps, separate clinic portals, calendars and spreadsheets. All of these can be useful. But as care becomes more complex — more specialists, more appointments, more people involved — the real challenge becomes keeping everything connected and current.

OURO is being built around that idea: that care coordination should be easier for families. Its purpose is to help families coordinate care, information, responsibilities and communication in one connected place — appointments, medications, care plans and the people involved, kept current and appropriately shared.

OURO MICRO-TIP If a medication changes, update the master list immediately rather than waiting until you have time to reorganise everything.

LEARN MORE ABOUT OURO

ourocare.com · Private Beta

> *"Who has the paperwork?"*

If that question sounds familiar, you're not alone — it's one of the most common things family carers say to each other. Building even a simple version of the system in this guide is enough to change the answer.



ABOUT OURO

OURO is building a simpler way for families to coordinate care.

Care often involves multiple people, responsibilities, appointments, information and decisions. OURO's purpose is to make that coordination clearer, more connected and easier to manage.

Produced by the team at OURO

Care coordination made simple.

ourocare.com

PRIVATE BETA

SOURCES & REFERENCES

Sources & References

Australian Government Department of Health, Disability and Ageing

My Health Record — health.gov.au/topics/health-technologies-and-digital-health/my-health-record
Modernising My Health Record — health.gov.au/our-work/modernising-my-health-record

Australian Digital Health Agency

My Health Record resources — digitalhealth.gov.au/initiatives-and-programs/my-health-record
Authorised & nominated representatives — digitalhealth.gov.au/.../authorised-representatives

Office of the Australian Information Commissioner (OAIC)

Health information and privacy — oaic.gov.au/privacy/your-privacy-rights/health-information
Guide to health privacy — oaic.gov.au/.../guide-to-health-privacy

Healthdirect Australia

Managing medicines and health information — healthdirect.gov.au

My Aged Care

Information for older people and carers — myagedcare.gov.au

Carer Gateway

Information and support for carers — carergateway.gov.au

Australian Commission on Safety and Quality in Health Care

Patient and carer resources — safetyandquality.gov.au

Disclaimer. This publication provides general information about organising health information and navigating care. It is not medical, legal or professional advice. Always speak with the relevant healthcare professional about medical decisions, medication changes or test results. Privacy and access rules can vary depending on the circumstances and jurisdiction. Information current as at August 2026.

Organising Medical Information for a Family Member is No. 007 in the OURO Resource Library, alongside The Family Care Starter Guide, Sharing the Care, and the Family Care Coordination Checklist — available at ourocare.com.