Referral

Purpose:

Provision of service must be co-ordinated across the full spectrum of care. The following policy sets out the minimum requirements for the management of referrals received by or made to other service providers as well as initiated internally between SCDHB services.

Scope:

All employees of SCDHB

Alert:

Referrals to more than one service

A separate ERMS referral shall be made for each service required.

If a patient has been referred to more than one service, and a consultant of one service is made aware of a change in the patient's health status that would be reasonably expected to be of concern to another service, then they shall inform the second service of the change, either verbally or in writing, and a note made of the discussion or written referral in the patient record.

If a patient has been referred to more than one service, correspondence sent by any one service to the GP shall be copied to every other service.

Policy Statement:

All referrals for primary, community, secondary, tertiary or diagnostic services for South Canterbury District Health Board patients are to be made to the SCDHB.

External referrals are written to the service required not to an individual clinician.

All referrals requesting radiological investigations are to be managed as per the policy for Referring for Medical Imaging.

Referrals received by SCDHB

Referrals will only be accepted if they meet the documented entry criteria for the service.

All referrals including First Specialist Appointment (FSA) for secondary and community services must be managed through the relevant entry point to the service. Where patients have had an FSA in the private sector and there is a recommendation for a surgical procedure, this must be sent to the Inpatient Booking Office to be prioritised in the same way as all elective bookings.

Departments providing community/secondary care services e.g. Emergency Department, Clinical Nurse Specialists, Therapy Services, Dietetics, Audiology and AT&R, Mental Health, Social Work and District Nursing must have in place a documented:

- entry criteria for the service
- process for receiving, recording and acknowledging referrals to referrer and patient, including the indicative waiting time.
- process for assessing referral for completeness and contacting referrer if information is missing
- approved tool for prioritising referrals
- clear process for who prioritises
- process for scheduling appointments
- process for responding to patients who self-refer

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- process for those patients declined entry to the service with recommendations for alternative options
- timeframes for referral management
- process for patients who fail to attend (including advice to the referrer)
- auditing of referral management e.g. timeliness of referral processing

<u>Referrals made within SCDHB services</u>
It is a requirement that patients are told when a request for an opinion has been made to a service including the name of the health professional that the referral has been made to. Where a transfer of care is agreed, the patient/family/whanau must be informed. Where the patient is unable to provide consent this must be sought from family/whanau or EPOA/guardian (see Informed Consent Policy CSPM I2).

All referrals should clearly communicate any need for urgent review.
It is courteous to ensure that all appropriate records, investigations and x-rays are available for the consultation.

A consultant to consultant referral for an FSA will be prioritised as for all primary and secondary referrals based on clinical need. Where it is the considered clinical opinion that an FSA appointment is not required then the consultant prioritising the referral will contact the referring consultant and discuss a treatment plan.

<u>Verbal referrals</u> for inpatients can be made at Multidisciplinary Team (MDT) meetings, by phone or informal discussion by a health professional provided the referrer documents an entry in the patient's clinical record indicating a verbal referral has been made. For inpatient psychiatric referrals there is a referral form.

Verbal referrals for community patients must be recorded on the appropriate referral form by the clinician receiving the referral and processed through the relevant entry point to service.

The health professional receiving the verbal referral must document the date and outcome of the consultation in the patient's clinical record.

Discussions between services may occur without the patient being physically assessed. It is good practice to make a written note of the conversation in the patient's clinical record.

<u>Written referral</u> for inpatients must be made using the appropriate referral form for the service requested.

Non urgent medical referrals to other secondary services within the DHB should be made in writing and sent to the Outpatient Appointment Office for processing.
Written referrals for community patients may be made via electronic communication or written referral. These will be processed in accordance with prioritisation tool.

<u>Referrals made to other service providers including other DHBs</u>
Urgent referral to another service provider should be made by the patient's lead clinician and would normally include a telephone call to both the receiving clinician as well as to the service the patient is being transferred to on acceptance. A written referral must accompany the patient on transfer with a copy filed in the patient's clinical file. Refer to transfer/transport policy in the Clinical Services Practice Manual. The patient/family/whanau must be informed.

Non urgent referral to another service provider should be made in writing and sent directly to the service provider with a copy of the referral filed in the patient's clinical file.

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Definitions:

FSA – First Specialist Assessment

Process:

For referrals within SCDHB the date and time for the following is required to be documented in the clinical record or on the referral form

- referral complete
- referral received
- acceptance of referral
- first initial face to face or phone contact with patient
- copy of the non-acceptance letter if referral declined or documented entry in progress notes pertaining to contact with referrer informing them of the non-acceptance to service and reasons for this.

For written referrals within SCDHB services all sections of the referral form must be filled in marking any sections that do not apply as 'not applicable' (N/A) – they should not be left blank. An entry in the clinical record is documented stating that the referral has been made. Referrals can either be faxed or sent by internal mail. Where the referral is faxed the original is placed in the patient's clinical record and if written a photocopy placed in the clinical record. If the referral has not been acknowledged within 24 hours, then this must be followed up e.g. by phone as a reminder with an entry made in the clinical record.

The health professional receiving the referral must document the date and outcome of the consultation in the patient's clinical record either in the progress notes or by completing the appropriate section of the referral form. The original referral form must then be filed in the patient's clinical record.

Subsequent to referral to another service, it is ideal for the consultant who gives an opinion to continue to be consulted if ongoing care or advice is required whilst the patient remains in hospital. Where follow up is required within the outpatient clinic ideally it should be with the same person who was consulted when the patient was an inpatient.

Associated Documents:

DNA Protocol for Hospital Stay Patients	CSPM D1
Service Frameworks	J:\General\Service Framework
Transfer/Transport: Patient	CSPM T3
Consultant to Consultant Referral	CSPM
Senior Medical Staff Handover	CSPM
Referring for Medical Imaging	CSPM

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