V. Referral Follow-Up System

A. Recommendations:

A Recommendation (as distinct from a Referral) is a suggestion to obtain a routine screening procedure when no abnormality has been identified (e.g. routine screening cholesterol or mammography) or a suggestion to follow-up on a minor health problem. If a recommendation is made, it must be documented in the chart. A referral form does not need to be given, but may be used at the discretion of the provider. Additional follow-up is at the discretion of the provider. The patient should be questioned/ reminded when she returns to the office.

B. **Referral** — advice to obtain a consultation, test, or management of any present or suspected acute, emergency, life-threatening, serious, or potentially life-threatening condition

C. **Required Components of a Referral** (Abnormal Pap tests also require referral/follow-up. See GYN Section on Cervical Dysplasia for protocol details.)

1. Alternate Mechanisms of Contact — An alternate mechanism of contact **must** be established and documented in the medical record if the patient has requested that confidentiality be maintained. Patients **must** be informed that confidentiality may be broken if they cannot be contacted when a life-threatening condition is suspected or detected. Notifying the patient is the first step in the referral follow-up process.
2. Listing of Agencies, Physicians, and Hospitals — There **must** be a listing of agencies, physicians, and hospitals to which patients may be directed or referred.
3. **Referral Forms** — The triplicate Medical Referral form **must** be used when the patient is at the health center for all referrals whether within or to an outside provider. The **white** copy **must** be given to the patient and/or mailed/faxed to the referral provider. The form **must** be signed and dated by the clinician making the referral. A copy of the form **must** be maintained in the medical record.
4. **Documentation of Referral** — All referrals **must** also be documented in the medical SOAP note and added to the Problem List. All referrals **must** be categorized and followed up as outlined below and as identified in the Medical Standards & Guidelines specific to that condition.

5. **Reminder System** — There **must** be an established reminder system to assure timely follow-up. The **pink** copy acts as the reminder system. The **pink** copy **must** be placed in the medical referral notebook (divided into acute and non-acute sections). For patients being referred out-of-affiliate for care, three referral sources should be given when possible. Once the patient is notified and the referral made, confirmation that care is being sought **must** occur within a designated timeframe. See grid at end of this section.
6. **Readily Identifiable Tickler** — There **must** be a readily identifiable reminder on the chart ("tickler") placed in a prominent place so that anyone looking at the chart for any reason (e.g., supply visit, telephone call) can take appropriate action. The **yellow** copy acts as this "readily identifiable tickler". It **must** be placed on top of the right hand side of the chart.

D. Referral Management – See grid at end of this section

Referral management **must** include:

1. **Patient notification**, verbal or written, **must** include:
   - the nature of the abnormal findings
   - the implications of the findings
   - the possible consequences of not receiving additional diagnosis and/or treatment
   - an explanation of management options and provision of appropriate referral sources, as indicated
   - informing patient that it is her responsibility to obtain follow-up care

Once contact has been established (e.g. with response to the first letter or phone call) and the patient has been informed of the above components additional patient contacts for notification purposes are not required.

2. Documentation of Patient Notification
   - The chart **must** include documentation that all the points in 2, above, have been communicated to the patient. It is only necessary to document these points once per referral.
   - If forms, form letters or other patient education materials are given or sent to the patient, they **must** either be cited in the medical record or a copy **must** be placed in the chart. If individual, unique letters are sent, a copy **must** be placed in the chart.

3. **Documentation of Confirmation of Care** — Once a referral is made, the affiliate **must** attempt to contact the patient to confirm that care was received (see grid for timeline). It is also the responsibility of any HCA or clinician looking at the chart for any reason (telephone call, pregnancy test, or other type of visit) to discuss and document confirmation of care. The chart **must** include documentation of all such attempts. In addition it **must** include:

- consent to release information to the referral source (patient signature line on triplicate referral form and/or Authorization to Release Medical Information)
- all attempts at contact and actual contacts with the patient or the referral source (with copies of any written communications)
- when known, a record of all visits and all missed appointments
- forms, form letters, or other patient education materials that are given or sent to the patient. They **must** either be cited in the medical record via a standardized identification system or a copy **must** be placed in the chart
- in circumstances where the patient will not receive care as recommended, the patient **must** sign Release When Test/Service/Consultation Will not be Obtained as Recommended before further clinical services can be provided.

E. **Abnormal Results Received by phone/fax/mail** (STI tests, ultrasound, radiology, and other bloodwork)

1. When abnormal lab results are received, the HCA **must** place the Red Follow-up Tickler on the front right hand side of the chart.
2. The chart **must** be given to the appropriate clinician or placed in the call-back box.
3. The Red Follow-up Tickler **must** then remain in place until the patient is contacted and either entered into the more formal medical or Pap referral follow-up system or follow-up is complete.

F. **Alert Notes** – Alert notes are notes in VISION to inform users of urgent medical information. Alert notes **must** be used when a patient can't be contacted by phone or mail for notification of a positive test result or confirmation of referral care. They **must also** be used when a patient develops an absolute contraindication to a birth control method or other medication.

G. **Staff** — There **must** be documentation in the personnel file of each staff person with patient contact that orientation was provided regarding that person's responsibility related to the handling and management of the Referral Follow-Up System. In addition, there **must** be evidence of ongoing training, particularly when the Referral Follow-Up System is updated. Referral training and documentation is part of the annual Professional Standard Review.

H. **Quality Management**

1. The referral/follow-up system **must** be audited at least annually to assure that patients requiring referrals are contacted in a timely manner, are provided appropriate information, and receive appropriate consultation/management.
2. Consumer feedback is encouraged and feedback obtained should be considered when updating the list of consultants.

CONDITION	NOTIFYING THE PATIENT	REFERRAL PROCEDURE	CONFIRMATION THAT CARE WAS RECEIVED
Level 1: **EMERGENCY** **Acute** (e.g., suspected ectopic, acute abdomen, thromboembolic event, acute PID, hemorrhage)	At time of visit -or- At time of emergency phone call **Must** make three attempts at notification. Two **must** be in writing.*	Give/call/fax referral form or information. Immediately transfer to ER or Hospital -or- With patient's consent, arrange immediate care. Initiate tracking system. "Tickler" on chart.	Call patient at least once within 72 hours. If no response to telephone attempt, **must** send first letter within seven days of initial referral. If no response to first letter, **must** send second letter within 14 days of initial referral. If no response, follow up when patient returns to clinic. Sign release as indicated in specific Standards. With patient's consent, request feedback from referral source.
Level 2: **Potentially serious or potentially life-threatening*** (e.g., dominant breast mass, adnexal mass, potential malignancy, STI)	At time of visit -or- Within designated time period for abnormal test results. See specific Standards. Make three attempts at notification. Two **must** be in writing* (unless otherwise noted in Standard).	Give referral form at visit -or- send/fax referral form. With patient's consent, help patient make appt, if necessary. Initiate tracking system. "Tickler" on chart.	Affiliate **must** make three attempts, two of which **must** be in writing, within 90 days of referral to confirm care* (unless otherwise noted in Standard). If test results show cancer the affiliate **must** make three attempts, two of which **must** be in writing, within 30 days of referral to confirm care. With patient's consent, request feedback from referral source. If no response, follow-up when patient returns to clinic. Sign release as indicated in specific Standards.

The aggressiveness of follow up shall depend on the potential seriousness of the problem.

* **Once contact is achieved (whether by phone or letter) no further attempts at contact are necessary.**