PATIENTS REFERRED FOR INVESTIGATIONS OR TO MEDICAL SPECIALISTS POLICY

CRITERION 1.5B

Patients attending the practice are informed of the potential for out-of-pocket expenses (additional to the consultation costs) when they are referred for investigation (e.g. radiology, pathology) or for initial consultation with a medical specialist or allied health professional to whom they have been referred about further fees that may arise.

- When referring a patient to a specialist or for tests, doctors are to warn patients that there may be additional costs and advise them to contact the specialist or laboratory prior to the appointment.
- If receptionists are making appointments for patients, they may enquire about additional costs if the patient requests them to do so.

PROCEDURE

Suggesting a referral to a particular practitioner or allied health professional carries with it an implicit endorsement that the receiving practitioner or service provider is appropriately skilled and qualified to administer the treatment or service. Generally this is not an issue, but if it is, the referral is quailed (e.g. If a patient requests a referral to a fringe practitioner the referral could read patient referral to you regarding xyz)

Our directory of local allied health providers, community and social services and also local specialists is available in **Best Practice → Open Contacts**

The patient is given information about the purpose, importance, benefits and risks associated with investigations, referrals or treatments proposed by their doctor to enable the patient to make informed decisions. The doctor may use leaflets, brochures or written information to support their explanation where appropriate. Clear communications about the unexpected developments can assist the patient to understand the need for additional costs.

Patients are advised of possible costs involved, including additional out of pocket costs, for procedures, investigations and treatments conducted on site prior to them being conducted. For referred services where costs are not known the patients are advised of the potential out of pocket expenses and encouraged or assisted to make their own enquires. If the patient indicates that the cost poses a barrier to the suggested treatment or investigation alternatives may need to be discussed (e.g. referral to public services).

Special care is taken to advise patients of the costs of consultations or procedures that do not attract a government subsidy.

REFERRAL LETTERS

Letter of referral are computer based. Referrals sent electronically should be encrypted via Medical Object or HealthLink. Practice letterhead is used for referrals. For medico legal and clinical reasons practices need to keep copies of important (non-routine) referral letters in patient health record.

In the case of an emergency or other unusual circumstance a telephone referral may be appropriate. A telephone referral needs to be documented in the patient's health record.

Referral letters should:-

- Typed and on appropriate practice stationary
- Contain relevant background social information and history
- Contain the present problem and reason for the referral and additional relevant or sufficient information for continuing health management and to avoid duplication
- Include relevant health problems, key examination findings and current management
- Include allergies, adverse drug reactions and a current accurate medications list
- Include the reason/purpose for the referral and expectation of the referral
- Identify the setting from which the referral is being made and also the setting to which the referral is being sent
- If known, identify the healthcare provider to whom the referral is being made
- Be dated
- Contain at least 3 of the approved patient identifiers e.g. name, date of birth and address
- Be electronically transmitted in a secure manner if appropriate.

Requests for pathology, diagnostic or other investigations should:

- Be legible
- Contain relevant clinical information
- Contains at least 3 of the approved patient identifiers e.g. name, date of birth and address

For medico-legal and clinical reasons copies of any clinically significant referral letters, pathology, diagnostic or other investigation requests and especially those which contain significant clinical details, are retained by the practice and documented in the patients' medical record.

- A copy of significant or non-routine referrals is kept electronically in the medical record
- Results of referrals and continuation notes or letters received from consultants and hospital are also retained in the patient health record
- Clinically significant referrals are followed up.

PATIENTS SEEKING ANOTHER OPINION

Patients seeking a further clinical opinion from another healthcare provider are encouraged to notify their General Practitioner to allow an opportunity to reinforce any potential risks of the decision. Any advice or actions taken when a patient seeks a further clinical opinion or refuses recommended clinical management are documented in the patients' health record. (Refer to **Management of a patient refusing treatment or advice**).