Practice Policy & Guidelines

Policy: Referring to a Specialist	Developed by:	Approved by:
Updated:	Signature:	Signature:

PURPOSE:
To ensure that all patients of (insert practice name) have continuity and coordination of care as they may require at other facilities and/or require transfer/transition to other entities for appropriate care.

GOALS AND OBJECTIVES:
To provide/retrieve appropriate and timely medical information to achieve optimum health outcomes for our patients.

RESPONSIBILITY:
Entire staff

DETAILS:
(Insert practice name) understands the importance of access to clinically relevant information. In keeping with the practice's goals, (insert practice name) participates in the real-time Immunization Registry and transfers information hourly to the immunization registry regarding any immunizations administered in our office. This is accessible to any other entity that has access to the registry data. In addition, (insert practice name) queries the immunization registry for any immunization information that seems incomplete in our patient chart, for any new patients, and for patients who report they received immunizations elsewhere.

In addition, all patients have access to a patient portal account, which allows them 24/7 web access to important information such as current/chronic medications, immunization records, growth measurements and allergies.

Referring for care:
All patients who are sent to outside facilities/specialists for care will have relevant medical information provided to the outside facility/specialist. Whenever possible and appropriate, if a patient is referred to an outside emergency department (ED) for care, the physician or designee will notify the ED of the patient's anticipated arrival and relevant clinical information provided over the phone or via fax. The transfer of information will be noted in the patient message record. When a patient is referred to a specialist, the physician or their designee will provide a

copy of relevant portions of the patient medical record to the patient or directly to the specialist via phone or fax.

In addition, (insert practice name) has fax server bi-directional information with three local hospitals and most specialist providers. Reports of diagnostic studies, emergency room visits and newborn records are sent and received directly via our main fax server preventing misdirection of "paper" reports. Reports are transferred directly into the patient's electronic chart. Ongoing triaging of hospital lab and diagnostic studies are done by licensed pediatric nurses prior to transfer to chart with direction of critical results to another physician in the case of an ordering provider being out of the office that day.

Patients who receive outside care:
Currently the three most commonly utilized emergency departments in our area automatically "auto-fax" a report to our office on any of our patients who are seen in the ED and indicate that an (insert practice name) provider is their primary care physician (PCP). Assigned staff who arrive in the office each morning, are directed to check the reports on the fax server via their logon to the server through their PC or laptop at 7:30am, 11am, 4pm and 6pm for information received overnight and periodically during the workday. All ED reports are sent directly to the physician and saved into the patient's electronic health record (EHR). Primary physician (or if not present, a covering practice physician) will review, extract pertinent information into the EHR and either follow-up directly with the patient/family, or instruct office staff to do so. Office staff will proactively contact any patients seen in the ED to either arrange for appropriate follow-up in our office or with a specialist to make certain the patient's problem has been resolved satisfactorily. Disposition will be documented in the message center of the EHR or documented on the ED report, which will then be scanned into the medical record.

The "rounding" physician is responsible for accessing the (insert hospital name) electronic system to identify any admitted or newborn patients. That physician can also access the same system to look at the list of patients treated in the emergency room.

Patients who are admitted to outside institutions will be proactively contacted. Any verbal or written reports received by the office via our fax server from outside institutions, clinicians or patients and families, will be transferred (scanned if received via postal mail) into the EHR. All information and reports are sent via electronic health record (EHR) to physicians for review and co-sign. Physicians or their designee will then proactively contact the patient/family to arrange for appropriate follow-up care, and assist in coordination of specialty care, if necessary.

Patients who receive care from specialists will be tracked within the EHR referral system if referred directly from our office. All specialist reports will be given to the physicians for review. Important data will be extracted from written reports and put in the EHR. Any necessary follow-up on diagnostic tests, medication and/or treatment plan will be noted and physicians or staff will proactively contact patients to ensure appropriate follow through. Received reports from specialists will be scanned into the medical record.

This policy shall be reviewed at least every 2 years.

Approved Date: _____/_____/_____

APPROVALS:

Physician Partner: _____ Date: _____/_____/_____

Administrative Partner: _____ Date: _____/_____/_____