

## Referral Documents

If a patient requires referral to an external health care provider, particular care needs to be taken with the referral document as to the type of information provided and how it is presented.

### **RACGP 4<sup>th</sup> Edition Standards**

- 1.6.2**      *Our referral documents to other health care providers contain sufficient information to facilitate optimal patient care.*

### **Assessment methods**

- Document review of patient health records

The GP Surveyor will review a random selection of patient health records during the practice visit. Practices will demonstrate that referral letters are legible and are documented in patient health records. Should the random selection not contain enough evidence for the surveyor, the practice may be asked to select further files containing referral letters.

### **Meeting the standards**

Referral letters will be legible, contain at least three approved identifiers, state the purpose of the referral and, where appropriate, include relevant history, examination findings and current management; include a list of known allergies, adverse drug reactions, and current medicines; and identify the GP making the referral, and the healthcare setting and healthcare provider to which the referral is being made.

All referrals will be on appropriate practice stationery, and a copy of all significant referrals shall be kept in the patient's health record.

The Practice should follow-up significant referrals to ensure the patient attended his or her appointment with the external health care provider, and that the results are received, reviewed and recorded by the practice.

Patients should be advised that their patient health information is being forwarded to another health care provider.

To ensure a smooth transition from GP to external health care provider, the referral document should be typed.

A telephone referral may be appropriate in emergency situations and this should be documented in the patient's health record.

**Best practice:**

- Referral letters are typed, legible and contain the necessary information from the patient's health records.
- A copy of all significant referrals is kept in the patient's health record.
- The practice follows-up significant referrals to ensure that patients have attended their appointments with the external health care provider and that the results have been received by the practice.