

REFERRALS WITHIN THE PROFESSION

2007

1. PREAMBLE.

- 1.1 The AMA believes the role of the General Practitioner to be central to the patient's management. As the first point of contact and the primary care provider, the general practitioner is responsible for coordinating the ongoing health care of the patient, in consultation with consultant colleagues and allied health professionals, whether in public or private practice.
- 1.2 The referral of patients from the general practitioner to consultant colleagues is one of the strengths of the Australian medical system. The referral serves as a formal link between general practitioners and consultants. It provides valuable two-way communication towards optimal patient care.
- 1.3 Patients should be actively involved in the interaction between general practitioner and consultant.
- 1.4 With the paramount emphasis on early and appropriate communication between general practitioner and consultant, the following principles are a guide for referrals within the profession.
- 1.5 Referrals within the profession can be from GP to Consultant; Consultant to Consultant; GP to GP; Consultant to GP. They may also include public hospital to private practitioner.
- 1.6 Doctors must be mindful of the Privacy Act 1988, but consideration of privacy must not interfere with good communication.
- 1.7 GPs have an obligation to act as a gatekeeper to health services. They must take this role seriously and ensure that all referrals are appropriate.
- 1.8 If a patient asks a GP to make an inappropriate referral, the doctor has the right to refuse that request, should explain their decision to the patient and document it.

2. LETTERS OF REFERRAL.

- 2.1 A routine referral should be in writing or alternatively transmitted by electronic communication. Urgent referrals may be verbal, but should be confirmed by a written referral.
- 2.2 Any referrals transferred electronically must be encrypted.
- 2.3 Every patient must have a referral letter, and, except in an emergency, the referral letter should accompany or precede the patient's attendance.
- 2.4 It is recognized that some patients self-refer to consultants without a referral letter. While this is to be discouraged, patients' rights of access should be respected. If a patient chooses to self-refer a lower government rebate applies.
- 2.5 The referral process, whether for new referrals or continuing referrals, is more than just completion of a form, but incorporates clinical decision-making by the referring practitioner.
- 2.6 The content of a referral could include the presenting complaint and the reason for the referral, relevant current clinical information including allergies and drug sensitivities, relevant past history, current medications, relevant history of past medications, and results of relevant and recent investigations.
- 2.7 Referring practitioners may wish to convey additional information about a patient which may be conveyed by the referring practitioner in other appropriate ways.
- 2.8 The referring practitioner should indicate whether the consultant is being asked for an opinion only, for management with an episode of illness, or to take over the management of the patient within the consultant's field of expertise.

- 2.9 If the referral is for a second opinion, the referring practitioner should indicate that.
- 2.10 Where a referral letter is not mandatory for the patient to receive a Medicare rebate, a letter containing essential information should still be forwarded to ensure continuity of care.
- 2.11 It is important all doctors ensure that patients fully understand the importance of a referral.
- 2.12 Every referral made must contain adequate detail. This is vital so the doctor receiving the referral has access to all relevant information and can provide best practice care to the patient.

3. CONSULTANTS' LETTERS.

- 3.1 As soon as practicable after an episode of care, the consultant should write to the referring practitioner. A letter should normally be written even if there is no change in the clinical condition or planned management. Exceptions arise if the consultant is seeing the patient very frequently, in which case letters at periodic intervals might be appropriate.
- 3.2 The consultant letter could contain relevant history and clinical findings, opinion with respect to pathology and diagnosis, and a summary of management actions and plans.
- 3.3 Consultants' communications inform the general practitioner of developments in the patient's care, and comprise part of the primary care record. The form and speed of communication should correlate with clinical circumstances.
- 3.4 Consultants' communications can be a valuable source of continuing education for general practitioners.
- 3.5 If the referral is made by a locum or other practitioner acting on behalf of the patient's usual practitioner, the locum should request that the consultant letter be sent back to the patient's usual practitioner, noting the referring practitioner. The consultant should consider sending a copy of the return letter to both the referring practitioner and the patient's usual general practitioner.
- 3.6 Many patients attend two or more general practitioners. Where possible, the consultant should identify whether the patient has multiple general practitioners and should seek the patient's consent to send copies of the return letter to each practitioner usually involved in the patient's care.
- 3.7 When a patient moves or otherwise changes general practitioner, general practitioners and consultants should, on receiving requests for copies of past correspondence, facilitate the free flow of information to new treating doctors.

4. ASSISTANCE AT OPERATIONS.

- 4.1 It is appropriate for proceduralists to consider inviting the referring practitioner to assist at any operations on the referred patient.

5. RETURN OF PATIENTS TO REFERRING PRACTITIONERS.

- 5.1 To ensure continuity of care, consultants must return patients to the referring practitioner as soon as is practicable for continuing primary care management.
- 5.2 On discharge from hospital, the consultant or hospital doctor must communicate with the patient's general practitioner and convey as much information as is necessary for the general practitioner to actively participate in the patient's continuing management.

- 5.3 The role of every consultant involved in a patient's care must be clear. In particular, the doctor coordinating the patient's care must be clearly identified to the patient and all the doctors involved in the care, including the original referring GP.
- 5.4 Consultants should recognise that referred patients may need to see their GP for other matters during the time that the consultant is treating the problem for which the patient was referred.

6. INTER-CONSULTANT REFERRALS.

- 6.1 Consultants should generally contact the referring doctor and/or the patient's usual practitioner before referring a patient to a second or subsequent practitioner including allied health or special interest clinics.

7. NON-RECOMMENDED REFERRALS.

- 7.1 Retrospective referrals are discouraged because they disengage the referring practitioner from the development of a cohesive plan of patient care.
- 7.2 Indefinite referrals are discouraged because they are a threat to the continuity of care and continuing engagement of the general practitioner in the patient's care.
- 7.3 Where the referral is indefinite, the consultant and referring doctor must continue to keep each other informed of the patient's progress at regular intervals.
- 7.4 For a repeat referral, staff should be instructed that the patient should return for consultation with the general practitioner in order to obtain an up-to-date valid referral letter.
- 7.5 In the event that a consultant sees an unreferral patient, consultants and their staff should not request patients to obtain retrospective referrals.

8. STAFF MATTERS

- 8.1 It is recommended that both general practitioners and consultants ensure that their staff are accurately trained in the legal requirement for referrals as required by Medicare Australia.
- 8.2 It is recommended that all practice staff are trained to be aware of their role in promoting effective communications within the profession, including effective and timely referrals. Practice staff should be trained not to place any barriers in the way of communication between doctors.
- 8.3 Practice information booklets could describe to patients the policies of the practice in relation to referrals. General practitioner information could include the reason for referrals and the role of the consultant as a partner in the treatment team. Consultant information could reinforce the reasons for the need to return to the referring general practitioner.