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भारत सरकार
स्वास्थ्य एवं परिवार कल्याण मंत्रालय
स्वास्थ्य सेवा महानिदेशालय
Government of India
Ministry of Health & Family Welfare
Directorate General of Health Services

T-20013/2/2024-SAS-1
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Subject: **Guidelines for Inter-Departmental Referral (within hospital)**

Dear Friends & Colleagues,

Inter-departmental referral process is a crucial component of high-quality comprehensive patient care in any medical institution. A substantial number patients have multiple comorbidities that need cooperation between departments.

However, there are significant variability, inconsistencies and lack of accountability in the referral process. Problems such as lack of hierarchy in references, communication, vagueness of references and indecisive reference notes, non-standardized formats, and inadequate training of healthcare professionals are common, and they ultimately can potentially harm a patient.

To address these issues, the Directorate is issuing Guidelines for Inter-Departmental Referral (within hospitals). These guidelines provide a framework to various hospitals. Hospitals are encouraged to develop their own Standard Operating Procedures/Policies to suit their internal setup.

I hope these guidelines will improve patient care services, facilitate better communication and cooperation between departments, enhance working relationships, help develop accountability and contribute to training of residents.

Will be grateful, if these guidelines are used positively to develop internal SOPs for use by all Medical Institutions.

With warm Personal Regards,

Yours truly,

(Atul Goel)

Encl.: Guidelines for Inter-Departmental Referral (within hospital)

To

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GUIDELINES FOR INTER-DEPARTMENTAL REFERRAL

(WITHIN HOSPITAL)

2024

These guidelines are expected to serve as broad guiding principles. Hospitals can implement these guidelines as per local needs and resources; they are expected to improve patient care and help develop accountability within the Institutions

FOREWARD

The referral process is a crucial component of high-quality patient care in any medical institution. Many patients who visit hospitals have multiple co-morbidities and need a multi-disciplinary approach. As an internist with experience ranging from a resident to a senior faculty member, I have observed significant variability and inconsistencies in the referral process. Problems such as poor coordination and communication, unclear procedures, non-standardized formats, and inadequate training for healthcare professionals are common. The roles of various professional levels are often undefined, resulting in gaps in patient care. To address these issues, a uniform guidance document was deemed necessary. This document aims to provide broad guiding principles that hospitals can adapt to their local needs and resources. It is expected to enhance patient care and foster accountability within institutions.

I hope these guidelines will improve patient care services, facilitate better communication between departments, enhance working relationships, and contribute to the training of residents.

May, 2024

Prof. (Dr.) Atul Goel
Director General of Health Services,
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SECTIONS

BACKGROUND & INTRODUCTION

- Good Patient care services need to be comprehensive. A patient can have multiple co morbid medical conditions and a single medical condition can have multi system manifestations. For comprehensive medical care, inputs from different departments are essential, which requires a Robust referral policy.
- Inter-departmental referrals typically occur when a patient requires services or expertise beyond scope of an admitting department. This may include specialized consultations, diagnostic procedures, therapeutic interventions, or ongoing management by a different specialty. Referrals can originate from various departments within the hospital, including primary care, emergency medicine, specialty clinics, and surgical services.
- A robust and efficient referral mechanism should be an essential part of training of residents as well. After residency as they enter a healthcare setup to practice, this training will be very useful for them.
- Inter-departmental referrals also serve as opportunities for interdisciplinary collaboration and sharing of knowledge among healthcare providers.
- By leveraging expertise and resources available across different specialties, hospitals can optimize patient care outcomes, enhance diagnostic accuracy, and improve treatment effectiveness. Moreover, referrals enable continuity of care by promoting coordinated management of complex medical conditions and facilitating follow-up care after discharge or treatment completion.
- However, problems can arise in any inter-departmental referral process, including:
  - Delays in processing/attending of referrals,
  - Breakdown in communication, and
  - Variations in referral practices across departments.
- To address these challenges, hospitals must implement standardized referral protocols, streamline referral workflows, and provide education and training to healthcare providers and staff involved in the referral process. Additionally, ongoing quality assurance and monitoring mechanisms are essential to evaluate the effectiveness of the referral process, thereby identifying areas for improvement, and ensuring compliance with regulatory requirements and best practices.
- Currently, with no clear guidelines in place, it has been observed that there exist heterogeneous referral mechanisms. Every department and individual have their own way of sending and attending referrals. The documentation is also variable and inconsistent. There are delays in attending to referrals which can affect patient care adversely. Mostly junior residents (first- or second-year post-graduates) see referrals where higher order inputs may actually be required. There are conflicts between departments regarding referrals which are mostly rooted in lack of communication.

GENERAL PRINCIPLES

1. Referral for Consultant's opinion should only be written by Consultants.
2. PG residents should not close referrals on their own without discussing with Senior Resident/Consultant.
3. Consultant on call should review the referral record of referrals attended to by his team the previous day. (This is expected to improve patient-care and enhance learning of residents)
4. After seeing the referral, a clear need for review should be indicated by the attending team. In case of such a need one may not wait for a formal call and see the referral on one's own as well, in interest of patients care.
5. Departments can prepare a roster with names of officers in various units with contact numbers & availability of units on different days, time; place where referral needs to be sent. This should be available on website as well as well circulated within the Institution. Surgical units may also indicate availability of alternate unit(s) on OT days. These lists are a living document and should be updated periodically.
6. The case record file of patients should have a sheet listing the various referrals taken in a chronological manner for ease of review.
7. The process of referral should be clearly explained to the patient and attendants/family by the referring department.
8. After seeing a referral, the patient and family should also be explained about the advice.
9. Referral should help patient management without burdening the referring department with a huge list of investigations. Any investigation by the referral team should be completely justified from the diagnosis offered.
10. When a team goes to see a referral, they should communicate (discuss with the doctor available/call the concerned Consultant/SR) of the referring team and vice versa. Such clear communication will improve patient care, enhance learning, and improve working relationships.

DO'S AND DON'TS FOR INTER-DEPARTMENTAL REFERRALS AT HOSPITALS:

Do's:

1. Initiate referrals promptly as and when patients require specialized care, diagnostic evaluations, or consultations beyond scope of admitting department.
2. Document referrals accurately and comprehensively, including relevant clinical information, expected outcome from referral, patient preferences, and any other specific instructions.
3. Communicate clearly and effectively with receiving departments, providing necessary clinical information and patient context to facilitate appropriate evaluation and management.
4. Acknowledge receipt of referrals promptly and provide timely updates to referring providers on status of referrals and patient appointments.
5. Collaborate with receiving departments and specialists to ensure continuity of care, shared decision making and optimal treatment outcomes for patients.
6. Follow up on referrals and coordinate care transitions, ensuring that patients receive necessary follow-up appointments, treatments, and interventions.
7. Respect patient confidentiality and privacy when sharing patient information with other departments or healthcare providers.
8. Seek feedback from referring providers and receiving departments to identify areas for improvement and enhance the efficiency and effectiveness of the referral process.
9. Adhere to hospital policies, regulatory requirements, and best practices governing inter-departmental referrals to ensure compliance and patient safety.
10. Prioritize patient-centered care, considering patients' preferences, values, and treatment goals in referral process and treatment planning.

Don'ts:

1. Don't delay referrals unnecessarily, as this may compromise patient care and lead to adverse outcomes.
2. Don't omit essential clinical information or documentation when initiating referrals, as this may impede the receiving department's ability to provide appropriate care.
3. Don't assume that all referrals are routine or non-urgent; carefully assess each patient's clinical presentation and urgency to determine appropriate level of prioritization.

4. Don't overlook communication with patients regarding the referral process, including informing them of the reason for referral, expected next steps, and any necessary follow-up appointments.
5. Don't rely solely on verbal communication for referrals; ensure that all referrals are documented in the patient's medical record or electronic health record (EHR) for accuracy and accountability.
6. Don't hesitate to escalate urgent referrals or seek assistance from senior colleagues or hospital administrators if there are delays or barriers to timely referral processing.
7. Don't breach patient confidentiality with unauthorized individuals or departments without proper consent or authorization.
8. Don't ignore feedback or concerns from referring providers or patients regarding the referral process; address any issues promptly and implement corrective actions as needed.
9. Don't overlook importance of ongoing education and training for healthcare providers and staff involved in the referral process to ensure competency and adherence to best practices.
10. Don't lose sight of patient's overall well-being and experience throughout the referral process; prioritize patient-centered care and advocacy at every stage of care delivery.

SPECIAL SITUATIONS

Special situations may arise during follow-up of referrals that require particular attention and handling. Here are some special situations and strategies to address them:

1. Referral Denial or Rejection:

- If a referral is denied or rejected by the specialist or receiving department, communicate the reasons for such denial to the referring department with alternative options for care.
- Providing additional information or documentation to support the referral request and address any concerns raised by the specialist.

2. Patient Non-Attendance:

- If the patient fails to attend the scheduled referral or is not on the bed, follow up with the patient/treating team to determine the reasons for non-attendance and address any barriers or concerns.
- Reschedule the visit if necessary and provide reminders and support to ensure the patient is available at rescheduled time.

3. Urgent or Emergent Referrals:

- For urgent or emergent referrals requiring immediate specialist evaluation, expedite the referral process by directly contacting the specialist or receiving department and communicating the urgency of the referral.
- Prioritize appointment scheduling and coordinate with ancillary services to ensure rapid access to necessary diagnostic tests or procedures.

5. Complex Care Coordination:

- In cases involving complex medical conditions or multidisciplinary care needs, engage in comprehensive care coordination involving multiple providers, specialties, and support services.
- Establish a multidisciplinary team approach to develop and implement a coordinated care plan that addresses the patient's physical, psychological, and social needs.

7. Discharge Planning:

- For referrals made in the context of hospital discharge planning, ensure seamless transitions of care by coordinating post-discharge follow-up appointments, medications, and support services.

8. Referral for Transfer from one department to another

- This situation occurs when patient from one department is transferred to another citing reason that no major active intervention is required in the referring department and/or patient primarily needs intervention in the referred department. (This leads to frequent arguments between the two departments)
- During such transfer referrals, reason for transfer needs to be clearly mentioned.
- Referring department should note down the progress of patient since admission and the notes and reports should be arranged chronologically before transfer.
- Referring department should ensure that the patient is regularly reviewed after transfer without waiting for a referral call (at least once a day).
- Should the patient require transfer back, that should be done without creating problems or hurdles.
- Discharge of such patients should be done in a coordinated manner by the two (or more) departments with clear explanation to the patient regarding further course and outpatient follow-up.

9. Death of a patient

In case of death of a referred/transferred patient e.g in ICU/Dialysis Room/CCU, department where patient is in (at the time of death) should complete documentation and required paperwork required before handing over of mortal remains of patients.

10. Referral in Outpatient Department

- An EXIT counter can be set up or utilized if already present for this purpose.
- A patient referred from Dept A to Dept B should visit the designated EXIT counter to get an OPD slip of Dept B.
- Such patient should not be made to stand in normal counters' queue to make an OPD slip.
- This will save man-days of patient as well as associated expenses of transport and loss of wages of another visit (OPE).
- The power of making OPD slips ONLY FOR INTERDEPARTMENTAL OPD REFERRALS during routine OPD registration time and after the time of registration is over has to be given to the EXIT counter up to a specified extended time (9:30 AM to 1:00 PM could be an indicative time).

PERFORMAS

REFERRAL FORM FOR INTERDEPARTMENTAL REFERRAL

Department_____ Location of patient _____

Name of the patient: Age and gender: UHID:

Referral from: Unit:

Date of admission: Date and time of referral:

Type of Reference: **Immediate**/Urgent/Routine Bedside- Yes/No Medico-legal- Yes/No

Consultation required from:

Faculty/ Senior resident, Unit-_____, Department of _____

Admission diagnosis and procedure (if any)

Indication for Reference & Expected Outcome:

Consultation required for: Fresh Opinion/Follow-up opinion/**Transfer**

Sent by: _____(Faculty/ Senior resident)

Signature/Name/Date/Time/Stamp

Reference noted by: _____ Sign, Name and Stamp

(Faculty/Senior resident)

Unit: Date and time:

Reminder sent on (date and time):

Noted by: Name, date and time

Please turn over

POST REFERRAL ADVICE

Reference Seen by _____ at _____ (date and time)

History and Examination:

Diagnosis:

Advice:

Signature:

Name/Stamp:

To follow up on _____(Date) with_____(Name, Unit)

Repeat referrals to be sent to_____(Details of the unit)

REGISTER TO BE MAINTAINED BY NURSING STAFF

Referring Department	Receiving Department	Patient Information	Reason for Referral	Urgency	Date of Referral	Status Completed (with time) /Pending

Indicative List of some medical conditions classified as Immediate/Urgent/ Routine

(This is not a comprehensive list; this is just to guide the clinicians)

Immediate (Attend within 30 minutes)	**Urgent** (Attend within 6 Hours)	**Routine** (Attend before next working day preferably within 12 hours)

Medical Conditions

Any hemodynamic instability	All MLC	Clearance before elective OT*
Delirium	All in-patients	Any other
Seizures		
Stroke		
Respiratory failure		
Organ Failure		
Active bleeding		
PTE/DVT		
Sepsis		
AKI		
Any decompensated chronic condition		
Metabolic complications-hypoglycemia, DKA, severe hyperglycemia		

Obstetrical and Gynecological Conditions

Cardiogenic shock- in pregnancy		From OPD for any high risk - pregnancy - Heart disease, thyroid disorder, Gestational diabetes, Renal disorders, seizure disorders, jaundice etc
Pulmonary edema		From OPD for radiology evaluation
ARDS in pregnancy		From OPD for surgical help in complicated elective surgery
Emergency CS		From wards for same as above
Acute liver failure- AFLP		Psychiatry referral for postpartum depression, psychosis
Maternal collapse		
Refractory seizures		
CVA in pregnancy		
Vessel injury on OT table		
Bladder/ uretur injury on OT table		
Gut injury on OT table		
small girls with Sexual assault especially from Pediatric Surgery		
Urgent dialysis in pregnancy or postpartum patients		
Urgent CTPA - suspected embolism		

urgent NCCT CECT and USG in above conditions		
Purpura fulminans		
necrotising fasciitis		
cellulitis/ abscess		

Orthopedic Conditions

Polytrauma associated with Head injury, Chest injury, Abdominal injury, Perineal injury, Pelvis fractures, Other visceral injuries	Open limb injuries	Includes Ortho cases posted for semi-emergency / Elective surgeries in next 48 hours
Injuries with Vascular Insult	Ortho cases posted for Emergency surgery	Orthopaedic cases admitted for Evaluation and diagnosis
		Cases with multiple comorbs planned for surgery in next 4-7 days

*Many references are received in emergency for clearance before elective OT which is invariably scheduled on the next working day. This should be avoided.

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Note- These guidelines have been prepared to provide a framework to various hospitals. Hospitals are encouraged to develop their own Standard Operating Procedures/Policies to suit their setup.