

Model Specialty Out-Patient Referral Request Checklist

*(This information, which is recommended to be included **with all referrals**, can be communicated through any of several means including a paper-based referral form, detailed clinical note from last appointment, or a template within the Electronic Medical Record (EMR))*

1. Referring provider information

- a. Referring provider name, institution and contact information (including method for direct contact for urgent issues)

2. Patient demographics and scheduling information

- a. Patient name, demographics, and contact information (including surrogate if appropriate)
- b. Considerations that may require special arrangements by the consultant such as severe vision or hearing loss, non-English language preference, cognitive deficits, cultural factors, preference regarding who to include in treatment planning, etc.
- c. Insurance company name/type of coverage
- d. Indicate that patient (or surrogate) understands and agrees with the purpose of the referral
- e. If a face-to-face appointment is requested, indicate whether: (Choose one)
 - the patient will call to schedule an appointment
 - the specialty practice should contact the patient

3. Referral information

- a. Indicate the specific clinical question including a brief summary of the most relevant clinical information as it relates to your overall care plan.
- b. Urgency: (Choose one)
 - Urgent (local definition; often 1-2 days) Recommend direct communication between referring and referral practice; Minimally provide written justification for urgency
 - Subacute (local definition; often 1-2 weeks)
 - Routine
- c. Pending subspecialist/specialist evaluation, the anticipated referral-type is: (Choose one)
 - Previsit Advice ¹
 - Non Face-to-Face (information-only) consultation ²
 - Evaluate and Advise Consultation (with the goal to managing the problem remaining with the referring clinician)
 - Procedural Consultation (This is a specific request for referred to subspecialist/specialist to evaluate need for and perform if deemed appropriate a specific procedure.)
 - Co-Management with Shared Care (Referring clinician (e.g. PCP) maintains first call for the referral disorder) ³
 - Co-Management with Principal Care (Referred to subspecialist/specialist)

assumes first call for the referral disorder)⁴

- _____ Please assume Full Responsibility for Complete Transfer of all Patient Care
- d. Pertinent Data Set: Clinical information **directly relevant** to the referral question. May include results of recent office visit; care summaries; relevant lab and imaging data and/or specific clinical information requested by the referred to specialty/subspecialty practice prior to the consult. *Please refer to the pertinent data set recommendations for select specific conditions developed by medical societies that participated in the American College of Physicians' High Value Care Coordination (HVCC) project available at http://hvc-dev.acponline.org/physres_data_sets.html*

4. Patient's Core (General) Data Set: (Should be included with all referrals as an aspirational goal; use EMR-generated data/summaries when available):

- a. Active problem list
- b. Updated medication list; medical allergies
- c. Summary of any significant medical and surgical history not previously specified
- d. Summary of any significant family history not previously specified
- e. Summary of any significant behavioral habits/social history not previously specified.
- f. Care Team members --- List of physicians and other healthcare professionals (E.g. medical specialists/subspecialist, mental health professionals, case managers, etc.) participating in the care of the patient

5. Care Coordination

- a. Referring practice requests notification from the specialty practice of the following: (circle any applicable)
 - Receipt of the referral
 - Date of scheduled appointment
 - Decision to defer appointment and reason why
 - Patient cancellation or no-show for the appointment
- b. Referrals made from one non-primary care specialty to another (e.g. secondary referrals) are advised to include the notification of the patient's primary care clinician with patient consent.

¹ Previsit Advice: Previsit preparation or assistance which can take place before any type of referral can include establishment of referral guidelines; request for guidance regarding whether referral is to appropriate subspecialty/specialty; and guidance for pre-visit work-up. If referring and referred to practice have an on-going relationship, best to handle these issues through a formal care coordination agreement.

² Non Face-to-Face consultation: An information-only exchange intended to address a discrete question in lieu of an office visit. Depending upon the organization, these may be electronic, phone, or video-based exchanges between the referring provider and the subspecialist/specialist. Non face-to-face consultations should allow the subspecialist/specialist to convert the request to an office consultation for reasons of case complexity.

³ Shared care indicates that the care of the referred patient for a specified condition or set of conditions is shared between the referring clinician and the subspecialist/ specialist with the referrer assuming responsibility for most of the elements of care for the specified condition, unless other arrangements agreed upon.

⁴ Principal care indicates that the care of the referred patient for a specified condition or set of conditions is managed by the subspecialist/specialist with assumption of the elements of care for that condition, unless other arrangements are agreed upon.

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