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COLLEGE OF PHYSICIANS & SURGEONS OF ALBERTA

ADVICE TO THE PROFESSION

Referral Consultation

The College of Physicians & Surgeons of Alberta (CPSA) provides advice to the profession to support physicians in implementing the CPSA Standards of Practice. This advice does not define a standard of practice, nor should it be interpreted as legal advice.

Advice to the Profession documents are dynamic and may be edited or updated for clarity at any time. Please refer back to these articles regularly to ensure you are aware of the most recent advice. Major changes will be communicated to our members; however, minor edits may only be noted within the documents.

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Preamble

The *Referral Consultation* standard of practice applies to **all** regulated members who refer patients to consulting healthcare providers or provide consultation services.

Detailed and timely communication between referring and consulting practitioners is essential for successful patient care. The patient carries the ultimate risk when there is misunderstanding between care providers about their roles and responsibilities, or poor or incomplete information exchange, particularly missing diagnostic information or failure to communicate the urgency of care needed.

The *Referral Consultation* standard is intended to ensure:

- the referring regulated member has a well-identified reason for requesting the consultation and has completed a workup within their scope and expertise;
- the consulting practitioner has all the information necessary to make a timely determination to accept or not accept the referral:
- the patient receives timely notification of the consultation appointment date/time and updates as necessary; and
- the consulting regulated member provides a timely report to the referring practitioner that includes findings and recommendations for follow-up care, including any ongoing involvement by the consultant.

Consistency is expected across practice locales (rural versus urban, community-based private office versus university/health authority facility), organization (longitudinal care versus episodic care) and specialty (laboratory and diagnostic imaging included).

Patient care

DISCUSSING CONSULTATION

To meet the needs of their patients, every regulated member will have the need to consult with other practitioners who have specialized experience, knowledge or expertise, or can offer a different perspective. When consultation is appropriate, the referring regulated member is expected to fully inform the patient as follows:

- explain the clinical concern and reason for seeking a consultation, including what the consultation is for;
- identify the consultant, either a specific individual or a service (e.g., "I'd like you to be seen by an endocrinologist");
- obtain the patient's consent for the consultation; and
- clarify the role the referring regulated member will play in the patient's ongoing care (recognizing the ultimate decision about who will manage the care of the patient should hinge on a discussion between the patient, the consultant and the referring regulated member).

The referring regulated member should also inform the patient if there are likely to be out-of-pocket costs (e.g., if the consultation will be considered a third-party request or an uninsured service). However, it is the consultant's responsibility to provide cost details to the patient when arranging the appointment.

Effort is required to address any communication barriers patients may have (e.g., do not speak English, are deaf or hard of hearing, etc.). It is the referring regulated member's responsibility to inform both the patient and the consultant of any communication barrier(s) and to advise the patient to bring a translator or other communication aid to the appointment.

PATIENT REQUESTS

When a consultation request comes from a patient (e.g., a request for a "second opinion"), the discussion should explore the patient's reason(s) and the appropriateness of the consultation.

CPSA will not define what constitutes a "reasonable" request from a patient; reasonableness must be considered in context. The clinical problem, workup/care to date and patient's comfort with the referring regulated member should all be considered, as well as previous consultations for the same medical concern.

A regulated member who refuses a patient's request for a referral is expected to explain the decision to the patient and carefully document the conversation and rationale in the patient's record.

Submitting a referral request

A thorough, detailed referral is key to ensuring a consultant has the pertinent information to determine whether or not to accept a request. Referral requests that are vague or do not

contain enough background information may be rejected by the consultant, which prolongs the process and creates delays in patients obtaining care.

WHAT TO INCLUDE IN A REFERRAL

A referring regulated member is expected to include sufficient detail in the request to enable the consultant to determine if the referral is appropriate to their practice and expertise and to triage the urgency of the patient's clinical circumstances to ensure appropriate and timely booking.

Pertinent details include provisional diagnosis, clinical information (i.e., presenting symptoms and investigations to date) and whether the expectation is an opinion only, a transfer of care or joint management of the patient. The referral must be legible and in English; best practice would see the referral typed, not handwritten, to ensure clarity. A complete referral includes:

- the purpose of the referral (e.g., a general opinion, second opinion, specific advice/procedure, etc.);
- the history of the current medical problem(s), including findings of examination and investigations, as well as a provisional diagnosis (if applicable);
- if applicable, specific treatments tried (in chronological order) and responses to them;
- current medications and known allergies;
- relevant past medical, surgical, family, and/or social history; and
- an enclosure of diagnostic studies (e.g., lab tests, diagnostic imaging, etc.) and communications from other consultants pertinent to the referral (if applicable).

Best practice would see the referral typed, not handwritten, to ensure clarity.

The referring regulated member should explicitly identify when the referral is solely for the purpose of a third-party request.

Information regarding communication barriers should be included in the referral request.

The patient's current telephone and mail contact information are also essential. While much of this information may be in a centralized database (e.g., Netcare), not all regulated members have access to all databases, and it's important to confirm the information is up to date.

Incomplete or incorrect patient contact information is a significant barrier to consultant offices in providing timely notification of a consultation appointment.

LABORATORY AND DIAGNOSTIC IMAGING (DI) INTERPRETATION

Interpretation of lab and DI results by a consultant pathologist/radiologist reasonably requires relevant clinical information from the ordering regulated member. This is considered a consultation, particularly when the results are more urgent, such as reporting on microbiology specimens. Therefore, a regulated member requesting a lab or DI investigation should provide pertinent clinical information on the requisition.

TRANSMISSION

Fax, mail or a secure electronic system (e.g., Alberta Health Service's eReferral, EZreferral, Dr2Dr) are the preferred methods for transmitting consultation requests. When a request is made solely by telephone, it is often difficult for the consultant office to determine the true extent of the patient workup. In this case, the consultant office should question the referral office to ensure all pertinent clinical information is obtained for appropriate triage.

As access to the provincial electronic medical records is not yet universal, it is inappropriate for a referring or consulting regulated member to direct another practitioner to this electronic database to find information, except in the case of an urgent referral where both practitioners agree to review the data electronically.

A routine consultation request **must not** be sent concurrently to multiple practitioners.

URGENT REQUEST

Urgent consultation requests **must be made by telephone** directly to the consulting practitioner or emergency service to ensure timely response. The routine marking of faxed/mailed consultation requests as "urgent" is inappropriate and not useful to the consultant performing triage.

Generally, a consultation request is considered urgent when a patient can reasonably be expected to suffer harm without timely (measured in hours to days) review by a consultant. CPSA cannot define the concept of "urgency" other than to state the patient's clinical presentation will determine the urgency of the request.

SHARED INVESTIGATIONS

While the standard requires referring healthcare providers to ensure they have evaluated and worked up the patient—including pertinent investigations—within their scope of practice, once a referral is accepted, the consultant becomes responsible for ordering additional investigations. In most cases, any regulated member who determines an investigation is needed is responsible for ordering that investigation, tracking the results and managing any follow-up required.

However, it is reasonable for consultants to request a referring provider order specific investigations in advance of an appointment if it helps speed up the process and allows the patient to be seen sooner. The referring regulated member can confirm with the consultant that they will be responsible for follow up, then CC the consultant on the investigation(s) according to the *Continuity of Care* standard.

Anything else regarding the appointment, such as identifying the time and date to the patient, remains the responsibility of the consultant's office.

Accepting new referrals and waitlist management

Accepting a new referral is very similar to accepting a new patient, as consideration must be given to the patient's care needs and the consultant's ability to provide care, while still providing care to existing patients. Patients should generally be accepted on a first come, first served basis, free from discrimination, as stated in the *Establishing the Physician-Patient Relationship* standard of practice. Consultants should also consider urgency and clinical need, scope of practice, and wait list length. Consultants are required to:

- provide care to the best of their ability in an urgent medical situation where no other regulated member is providing care, regardless of whether a physician-patient relationship has been established;
- clearly and respectfully communicate to the referring healthcare provider why a referral has been declined to allay perceptions of discrimination, and document the rationale in their file; and
- triage referrals as they are received to ensure urgent requests are addressed in a timely manner based on each individual patient's information.

For further guidance, please refer to the Canadian Medical Protective Association's "Accepting new patients: Guidance for specialists" article and the Canadian Medical Association's *Code of Ethics & Professionalism*.

REFERRALS FROM OTHER HEALTHCARE PROVIDERS MUST BE CONSIDERED

As long as it is within a healthcare provider's scope of practice to make referrals and provide appropriate follow up care (e.g., ordering tests, prescribing medication, etc.) regulated members are required to accept valid, thorough referrals from **any** healthcare provider, not just physicians. For example, it is inappropriate to refuse a referral simply because it comes from a nurse practitioner.

Regulated members are not expected to know the scope of every regulated healthcare provider; however, if there are questions as to a referring practitioner's scope of practice,

the consultant should reach out to discuss the matter instead of immediately refusing the referral. The referring practitioner may recognize a health concern for which the consultation is required without necessarily having the background knowledge/scope of practice to provide the detailed referral expected from a healthcare provider. The referral request should not be dismissed out of hand without a discussion with the referring healthcare provider; similarly, the consultant may rightly accept the referral knowing that patient follow up may be with a different healthcare provider (i.e., primary care practitioner).

A key question to consider is whether a referral would be accepted if it were sent by a family physician (i.e., the test/request is appropriate and sufficient information has been provided): if so, the same referral should be accepted from another healthcare provider.

When declining a referral, regulated members are required to provide a reason, as well as suggestions for alternate care or consultation where possible.

Receiving and responding to consultation requests

The consulting physician is responsible for acknowledging receipt of a consultation request to the referring healthcare provider within seven days and informing them whether or not the request has been accepted within 14 days of its receipt. If the referral is not accepted, the consulting physician needs to provide a reason, as well as suggestions for alternate care or consultation where possible.

If the referral request indicates a communication barrier, as outlined in the "Discussing Consultations" section above, the consulting physician should remind the patient to arrange a translator or communication aid when scheduling the appointment.

If the referring healthcare provider gives insufficient information to enable the consultant to determine whether or not to accept the request, the consultant is expected to ask the referring healthcare provider for more information within the same 7-day timeframe. This is likely to trigger a conversation between the two practitioners that ensures future requests include all necessary information.

> If a referral is sent to a group practice without an identified physician, the referral may be triaged to the next available consultant. However, if a physician is named on the request, the referring healthcare provider should be given the option of being referred to another member of the group; otherwise, the referral must be given to the named consultant.

MULTIDISCIPLINARY/TEAM-BASED CARE

In multidisciplinary/team-based care models where referrals may be sent to a group, as opposed to an identified individual, including those with no physician lead, the standard of

practice still needs to be followed by CPSA-regulated members (i.e., response timelines). Generally speaking, consultation requests should be triaged by a clinician rather than clerical staff.

Where clerical staff triage referrals based on physician-approved templates, the physician will be responsible for ensuring the applicability of the template, as well as the adherence to the timelines required from the standard.

COMBINED CORRESPONDENCE

If the consulting physician's practice allows for receipt of referral, acceptance, treatment and providing a report back to the referring healthcare provider within the seven-day timeframe (e.g., palliative care where the patient receives treatment within a week), it is reasonable to send **one** letter acknowledging all three steps.

IS YOUR PROCESS "REASONABLE"?

If you are a consulting physician, the process you use to receive consultation requests **must** be reasonably accessible to referring healthcare providers and respectful of their time and resources.

A few of the more common concerns include, but are not limited to, lengthy voicemail menus, lack of response to messages and very limited timeframes for submitting requests (sometimes by telephone only).

CPSA determines "reasonableness" based on the experience of the referring healthcare provider and impacts on patient care. For example:

- It is NOT considered reasonable for a consultant to expect the referring healthcare provider's office staff to wait on hold for a significantly long time; with this process, patient care is also put "on hold."
- It is NOT considered reasonable for a consultant to accept consultation requests only on a "lottery system" basis (i.e., only those lucky enough to connect with the consultant's office staff within a very limited window for receiving requests are able to refer patients). Such a system fails both the prospective patient and referring healthcare provider it does not consider the clinical situation of the patient and inconveniences and frustrates the referring healthcare provider and their staff.

A system based on timely communication, mutual respect and the best interests of the patient will always meet the "reasonableness" test.

SUGGESTIONS FOR REGULATED MEMBERS IN SOLO PRACTICE

CPSA recognizes some consultants in solo practice may be challenged to meet the timeframes in the standard when taking time away from practice. Consider these possible solutions:

- **Arrange cross-coverage with another clinic(s).** Make advance arrangements with another clinic to triage consultation requests in your absence, and inform your typical referring healthcare providers. Coverage should include responding to (including provisional acceptance, as appropriate), but not necessarily arranging an appointment date/time with the patient.
- **Provide advance notice of time away to typical referring healthcare providers.** Consider giving at least 14 days' notice of the dates you will be away and not available to receive and respond to referral requests.
- **Formally merge into group practice.** While a more involved and permanent solution than those listed above, group practice does facilitate coverage for members during time away and offers the ongoing support of colleagues for urgent consultations.

As the practice of medicine matures and advances, regulated members also need to adapt their practices. Greater cooperation facilitates continuity of care and recognizes the profession's responsibility to patients.

Consultation appointment and follow-up

ARRANGING THE APPOINTMENT WITH THE PATIENT

Upon accepting a referral request, the consulting regulated member's office is responsible for arranging the appointment with the patient (hence the importance of accurate contact information from the referring healthcare provider) and informing the patient of any out-of-pocket costs associated with the consultation.

It is **not** acceptable for a consulting regulated member to expect the referring healthcare provider to inform the patient of appointment details.

If the appointment date can't be determined right away, the consultant is expected to update the referring healthcare provider and patient every 90 days (at minimum). How

this information is communicated is up to the consultant and patient, as long as the principles of confidentiality are followed.

REPORTING TO THE REFERRING HEALTHCARE PROVIDER

A consulting regulated member is required to provide a report to the referring healthcare provider within 30 days of the patient's first appointment regardless of their personal/practice plans (e.g., retirement). The referring healthcare provider needs timely access to the consult report to ensure their ability to care for patients discharged back to them.

As well as the elements outlined in the *Referral Consultation* standard, the report should indicate any ongoing involvement the consultant will have in the patient's care (e.g., follow-up, surgical procedures, etc.) with clearly written expectations of the role of the referring healthcare provider (and any other care providers).

If the consulting regulated member anticipates no further involvement with the patient, the report should clearly indicate the transfer of the patient's care back to the referring healthcare provider. It is best practice to ensure the patient clearly understands that they are being discharged back to their referring healthcare provider. As per the standard, the consulting regulated member is responsible for the care of the patient, inclusive of investigations and other follow-up, until such time there is clear agreement and communication regarding transfer of the patient back to the referring practitioner.

REPEAT AND INFORMAL CONSULTATION REQUESTS

A consulting regulated member who has indicated they will continue to see a patient on a regular basis for follow-up/accompanying care has established a longitudinal relationship with the patient. Implicitly, the consultant has agreed the patient will either be recalled directly or can book with the consultant directly and **must not** demand a repeat consultation request for follow-up appointments for the same clinical concern regardless of the time that has passed. However, if the patient develops a new clinical problem, it is reasonable for the consultant to require an updated/new consultation request.

In most cases, a new referral cannot be requested for an established patient simply because a specific length of time has passed (e.g., 12 months). If a patient is required to attend appointments annually but doesn't attend for a prolonged period of time where their medical history may have changed (e.g., two years), it may be reasonable to request a new referral to obtain the pertinent medical history.

A consulting regulated member who agrees to see a patient without a formal consultation request cannot subsequently ask the referring practitioner to provide one.

Tools and resources to facilitate referral consultation

The following tools are available to improve the quality of referrals and enable consulting regulated members to accurately assess the appropriateness of a consultation. They cannot, however, replace the occasional need for consulting and referring healthcare providers to speak directly with each other to make patient care work.

- QuRE checklist (AHS, the University of Alberta and the University of Calgary)
- Guide to Enhancing Referrals and Consultations: Developed by the College of Family Physicians of Canada and the Royal College, this guide provides advice on improving referrals and consultations between physicians.
    - To read the Referrals Consultation Guide please contact us at healthpolicy@royalcollege.ca

ALBERTA NETCARE EREFERRAL

Certain groups of consultants (e.g., lung tumour oncology, breast tumour oncology and the provincial hip and knee clinics) have agreements with the Netcare eReferral system, which allows referring and consulting healthcare providers to exchange information immediately through a secure electronic system. Use of eReferral is encouraged to minimize delays in transmitting referral requests, ensure information gets to the intended recipient and provide feedback to both physicians on whether timelines for response (seven and 14 days) are being met.

ALBERTA REFERRAL DIRECTORY

The Alberta Referral Directory (ARD) is AHS' designated system of record for referral information available to all healthcare practitioners in the province, including those without AHS privileges. The ARD eases the complexities of the referral process by eliminating the need to search, update and publish documents in multiple places throughout Alberta. The directory is comprised of service and consultant demographics, referral guidelines, referral forms and detailed instructions to facilitate referral acceptance without delay. Having updated referral information in a single source increases the likelihood of sending and receiving appropriate referrals with completed investigations and spending less time resubmitting and redirecting referrals. The ARD can help to reduce workload burden, save time, reduce operating costs and improve patient satisfaction and safety. Visit albertareferraldirectory.ca to access the directory.

Resources

CPSA team members are available to speak with physicians who have questions or concerns. Please contact support@cpsa.ab.ca.

RELATED STANDARDS OF PRACTICE

- *Referral Consultation*
- *Charging for Uninsured Professional Services*
- *Code of Ethics & Professionalism*
- *Continuity of Care*
- *Establishing the Physician-Patient Relationship*
- *Informed Consent*
- *Patient Record Content*
- *Responding to Third Party Requests*
- *Transfer of Care*

COMPANION RESOURCES

- Advice to the Profession:
  - Charging for Uninsured Professional Services
  - Continuity of Care
  - Informed Consent for Adults
  - Informed Consent for Minors
- AHS's QuRE Quality Referral Pocket Checklist
- CMPA's The Most Responsible Physician

Review Date	Revision/Change
Apr. 2024	Clarification responsibility in multidisciplinary/team-based care.
Sep. 2023	Shared investigations added.
Nov. 2022	Information added regarding accepting referrals/managing waitlists & combined correspondence.
July 2022	Detailed what fulsome referral includes.
June 2021	Updated to new branding/template.
Dec. 2019	Clarified referrals should be typed.
July 2019	Additional information added regarding Alberta Referral Directory.
Mar. 2018	Communication barriers addressed.