

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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Scope

The [Referral Consultation](#) standard of practice applies to all regulated members who refer patients to consulting healthcare providers (medical and other) or provide consultation services.

Purpose

Fulsome 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 physician has a well-identified reason for requesting the consultation and has completed a workup within his/her 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 physician 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 is foremost

DISCUSSING CONSULTATION

To meet the needs of their patients, every regulated member will, from time to time 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 physician is expected to fully inform the patient as follows:

- explain the clinical concern and reason for seeking a consultation,
- 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 physician intends to 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 physician).

The referring physician should also inform the patient if there are likely to be [out-of-pocket costs](#), for example 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.

Patients with communication barriers (e.g., do not speak English, deaf or hard of hearing, etc.) present a unique challenge, and additional effort is required to ensure these barriers are addressed. It is the referring physician's responsibility to inform both the patient and the consultant of any communication barrier 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 (sometimes a request for a "second opinion"), the discussion should also explore the patient's reason(s) for making the request and the appropriateness of the consultation.

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

A regulated member who refuses a patient's request for referral is expected to explain the decision to the patient and carefully document the reasons in the [patient's record](#).

Submitting a consultation request

CONTENT

A referring physician is expected to include sufficient detail in the consultation request to enable the consultant to make a meaningful determination whether the referral is appropriate to his/her 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. Ensure the referral is legible and in English; best practice would see the referral typed, not handwritten, to ensure clarity.

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

The patient's current telephone and mail contact information are also essential. **Incomplete or incorrect patient contact information is a significant handicap 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 physician. This is appropriately considered a consultation, particularly when the results are more urgent, such as reporting on microbiology specimens. Therefore, a physician requesting a lab or DI investigation should provide pertinent clinical information on the requisition.

TRANSMISSION

Fax, mail or a secure electronic system (e.g., AHS 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 appropriately question the referral office to ensure all pertinent clinical information is obtained for appropriate triage.

As access to the provincial EHR/Netcare is not yet universal, it is inappropriate for a referring or consulting physician 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

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.

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.

Receiving and responding to consultation requests

The consulting physician is responsible for acknowledging receipt of a consultation request within 7 days and informing the referring practitioner whether or not the request has been accepted within 14 days of its receipt.

Consultation requests should be triaged by a clinician rather than clerical staff.

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

If the referring practitioner provides insufficient information to enable the consultant to determine whether or not to accept the request, the consultant is expected to ask the referring practitioner 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.

IS YOUR PROCESS “REASONABLE”?

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

CPSA has heard from a multitude of referring practitioners about challenges submitting referral requests to consulting physicians. Protracted voicemail menus, lack of response to messages and very limited timeframes for submitting requests (sometimes by telephone only) are a few of the more common concerns.

CPSA determines “reasonableness” based on the experience of the referring physician and impacts on patient care. For example:

- It is NOT considered reasonable for a consultant to expect the referring practitioner's office staff to wait on hold for a significantly protracted 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 practitioner: it does not consider the clinical situation of the patient and inconveniences and frustrates the referring physician and his/her staff.

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

SUGGESTIONS FOR PHYSICIANS IN SOLO PRACTICE

CPSA recognizes some consulting physicians 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 referring practitioners. Coverage should include response (including provisional acceptance, as appropriate), but not necessarily arranging an appointment date/time with the patient.
- **Provide advance notice of time away to referring practitioners.** Give referring practitioners 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 offer 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 physician's office is responsible for arranging the appointment with the patient (hence the importance of accurate contact information from the referring practitioner) and informing the patient of any out-of-pocket costs associated with the consultation.

It is **not** acceptable for a consulting physician to expect the referring practitioner to inform the patient of appointment details.

If the appointment date can't be determined right away, the consultant office is expected to update the 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 PRACTITIONER

A consulting physician is required to provide a report to the referring practitioner within 30 days of the patient's first appointment. As well as the elements outlined in the [Referral-Consultation](#)

standard, the report should indicate what, if 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 practitioner (and any other care providers).

If the consulting physician anticipates no further involvement with the patient, the report should clearly indicate the [transfer of the patient's care](#) back to the referring practitioner. As per [the standard](#), the consulting physician 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 physician who has indicated he/she will continue to see a patient on a regular basis for follow-up/concomitant 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.

A consulting physician 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 physicians to accurately assess the appropriateness of a consultation. They cannot, however, replace the occasional need for consulting and referring practitioners 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 between Physicians](#) (College of Family Physicians of Canada)
- [Physicians and Nurse Practitioners: Working Collaboratively as Independent Health Professionals](#) (Canadian Medical Protective Association)

ALBERTA NETCARE EREFERRAL

Certain groups of specialists (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 physicians 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 (7 and 14 days) are being met.

ALBERTA REFERRAL DIRECTORY

The [Alberta Referral Directory](#) (ARD) is Alberta Health Services' 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 work load burden, save time, reduce operating costs and improve patient satisfaction and safety. Visit albertareferraldirectory.ca to access the directory.