HARDIN COUNTY GENERAL HOSPITAL
HOSPITAL-WIDE POLICY

Title: OUTPATIENT REFERRALS **Effective Date: 8/07**
Policy Number: 148 **Med Staff:**
Regulation: **Admin:**

I. POLICY

All patient referrals will be made in a timely and effective manner to the appropriate provider.

II. DEFINITIONS

N/A

III. RESPONSIBILITY

All departments making and receiving referrals.

IV. EQUIPMENT

Patient Referral Form and any other pertinent patient referral information
Referral Logs
Procedure prep handouts
Telephone
Fax machine
Charge slips for billing (Encounter form, requisition slips, etc.)

V. PROCEDURES

INFECTION CONTROL: N/A

Clinic:

1. The physician writes an order for a referral on the Encounter Form.
2. The Encounter Form is copied by the Receptionist and given to the Referral Nurse along with a copy of insurance information.
3. The procedure is pre-certified if applicable (commercial insurance, etc.).
4. The Patient Referral Form is completed by the person scheduling the procedure and signed by the ordering physician.
5. The procedure is scheduled by the Referral Nurse.
6. The patient is given a copy of the Patient Referral Form with the appointment date, time, location, and prep, if indicated, for the procedure.
7. A copy of the Patient Referral Form (physician order is on this form), Cumulative Patient Profile, current Medication list, and any other pertinent information (Progress Notes, Radiology and Lab reports, H&P, etc.) is faxed to the referred provider.

8. The original Referral Form is placed with the Progress Note which originated the referral on the patient record.
9. The fax sheet with confirmation is placed in the back of the patient record under miscellaneous for reference if needed.
10. The referral is logged in the Referral Log book under the appropriate ordering provider.

Emergency Room:

1. The physician writes the order for referral on the ER Record.
2. During regular business hours Monday through Friday, the ER Nurse calls the appropriate provider to schedule the appointment.
3. If it is a referral for outpatient procedures to be done at this facility and someone is in the department being referred to, the Patient Referral Form is to be filled out after it is scheduled with the appropriate department and given to the patient upon discharge from the ER. A copy of the referral should be placed with the ER Record.
4. If it is after business hours or the weekend, the ER Nurse makes a copy of the entire ER Record and any pertinent Labs, EKG, etc. and tacks it to the corkboard in the ER office in a manila folder marked Patient Referral. The referral is made by the ER Nurse here on the next business day when the referral can be made.
5. If the ER Nurse is too busy dealing with ER patients, the referral is to be given to Central Supply personnel to complete in a timely manner. If it happens that Central Supply personnel are also too busy the referral can be forwarded to the Ward Clerk (W/C) to be completed.
6. Once the referral is made, the patient is to be notified with the date and time.
7. The Patient Referral Form is completed and faxed with all other pertinent patient information to the appropriate provider.
8. The referral is logged in the ER Referral Log.
9. A copy of the Patient Referral Form is kept for reference if needed.

Inpatient: Acute Care, Observation Bed, & Swingbed Patients:

1. The physician writes an order for a referral.
2. During regular business hours, Monday through Friday, the W/C calls the appropriate provider to schedule the appointment.
3. If it is a referral for outpatient procedures to be done at this facility and someone is in the department being referred to, the Patient Referral Form is to be filled out after it is scheduled with the appropriate department and given to the patient upon discharge. A copy of the referral should be placed on the patient record or all information (date, time, prep, etc.) is written on the Discharge Instruction Sheet.
4. If it is after business hours or the weekend, the W/C makes a copy of the order and all other pertinent information from the patient record (Face Sheet, H&P, Discharge meds, Labs, etc.) and places it in the folder marked Pending Patient Referrals. The referral is made by the W/C here on the next business day when the referral can be made.

5. If the W/C is too busy dealing with other patient care issues, the referral is to be given to the ER Nurse to complete in a timely manner. If it happens that the ER Nurse is also too busy the referral can be forwarded to the Utilization Review Department to be completed.
6. Once the referral is made, the patient is to be notified with the date and time.
7. The Patient Referral Form is completed and faxed with all other pertinent patient information to the appropriate provider.
8. The referral is logged.
9. A copy of the Patient Referral Form is kept for reference if needed.

Radiology & Ultrasound:

1. Physician orders the procedure.
2. The Patient Referral Form is completed by the person scheduling the procedure and signed by the ordering physician.
3. The procedure is pre-certified if applicable (commercial insurance, etc.).
4. The Radiology Department is notified and the procedure is scheduled by the Radiology Department.
5. The completed Patient Referral Form and appropriate prep (if applicable) is given to the patient in writing. A copy of the Referral Form should be kept by the scheduling person for reference if needed.
6. The Radiology department is notified per phone of the referral and the referral form is sent to the department via the patient receiving the procedure.
7. The patient reports to the Front Desk with the Patient Referral Form on the day of the procedure to register.
8. The Front Desk sends the patient to the Radiology Department where they are directed to the procedure area.
9. The procedure is completed by Radiology/Ultrasound personnel and sent to the interpreting physician.
10. The report is transcribed by Medical Records and a copy of the report is sent to the Radiology department and to the ordering physician.
11. The referral is logged.

Rehabilitation (Rehab):

1. Physician orders the evaluation/procedure.
2. The Patient Referral Form is completed by the person scheduling the evaluation/procedure and it is signed by the ordering physician.
3. The evaluation is pre-certified if applicable (commercial insurance, etc.).
4. The Rehab Department is notified and the evaluation is scheduled.
5. The completed Patient Referral Form is given to the patient and a copy is faxed to the Rehab Department. A copy of the Referral Form should be kept by the scheduling

person for reference if needed.

6. The patient reports to the Front Desk with the Patient Referral Form on the day of the procedure to register.
7. The Front Desk calls the Rehab Department where they are then directed to the Evaluation/procedure area or will wait in lobby until called.
8. The evaluation/procedure is completed by Rehab personnel.
9. The report is transcribed by Medical Records (or documented by the Occupational Therapist) and a copy of the report is sent to the ordering physician.
10. The referral is logged.

Respiratory Therapy:

1. Physician orders one or more of the following procedures:

24 hour O2 Saturation	**Oximetry (O2 saturation)**
24 hour Holter Monitor	**EKG**
Spirometry	**PFT (Pulmonary Funtion Test)**
Sleep Study	

2. The Patient Referral Form is completed by the person scheduling the procedure and signed by the ordering physician.
3. The procedure is pre-certified if applicable (commercial insurance, etc.).
4. The Respiratory Therapy Department is notified and the procedure is scheduled by the Respiratory Therapy Department.
5. The completed Patient Referral Form and appropriate prep (if applicable) is given to the patient in writing. A copy of the Referral Form should be kept by the scheduling person for reference if needed.
6. The Respiratory Therapy Department is notified per phone of the referral and the referral form is sent to the department via the patient receiving the procedure.
7. The patient reports to the Front Desk with the Patient Referral Form on the day of the procedure to register.
8. The Front Desk sends the patient to the Respiratory Therapy Department where they are directed to the procedure area.
9. The procedure is completed by Respiratory personnel and sent to the interpreting physician.
10. The report is transcribed by Medical Records and a copy of the report is sent to the ordering physician.
11. The referral is logged.

Stress Testing; Tilt Table:

1. Physician orders the procedure. Scheduling at this time is dependent on availability of a physician.

2. The Patient Referral Form is completed by the person scheduling the procedure and signed by the ordering physician.
3. The procedure is pre-certified if applicable (commercial insurance, etc.).
4. The Central Supply Department is notified and the procedure is scheduled by the Central Supply Department.
5. The completed Patient Referral Form and appropriate prep (if applicable) is given to the patient in writing. A copy of the Referral Form should be kept by the scheduling person for reference if needed.
6. The Central Supply Department is notified per phone of the referral and the referral form is sent to the department via the patient receiving the procedure.
7. The patient reports to the Front Desk with the Patient Referral Form on the day of the procedure to register.
8. The Front Desk will call Central Supply and the patient will be taken to the procedure area by Central Supply personnel. They patient will be asked to wait in the lobby if another procedure is in progress ahead of them.
9. The procedure is completed by the appropriate personnel and sent to the interpreting physician.
10. The report is sent to Medical Records and a copy of the report is sent to the ordering physician.
11. The referral is logged.

Chemical Stress Testing:

1. If the patient is to be scheduled for a chemical stress test, it will be scheduled by Central Supply personnel. (Usually scheduled at Western Baptist Hospital(WBH)
2. The procedure is pre-certified if applicable (commercial insurance, etc.).
3. The completed Patient Referral Form and appropriate prep (if applicable) is given to the patient in writing. A copy of the Referral Form should be kept by the scheduling person for reference if needed.
4. If the patient will already be gone before the procedure is scheduled, a copy of the appropriate prep (if applicable) will be given to them before they leave from the consult, and the patient will be notified of the date and time of the scheduled procedure by phone. Any questions and/or additional instructions will be given to the patient then.
5. Central Supply personnel will fax the Patient Referral Form and other pertinent information (current medications, lab and radiology reports, etc.) to the Cardiology Department at WBH.
6. The referral is logged.

Surgical Consult:

1. Physician orders a surgical consult.
2. The Central Supply Department is notified and the consult is scheduled by the Central Supply Department. The patient will be notified by the scheduler at this time or will be notified by Central Supply personnel when it is scheduled.

3. The Patient Referral Form is completed by the person scheduling the consult and signed by the ordering physician. If Central Supply will be scheduling later, the scheduler should write that the patient will be notified by phone of the date and time of the consult.
4. The completed Patient Referral Form and appropriate prep (if applicable) is given to the patient in writing. A copy of the Referral Form should be kept by the scheduling person for reference if needed.
5. The patient reports to the Front Desk with the Patient Referral Form on the day of the procedure to register.
6. The Front Desk notifies the Central Supply Department that the patient is here.
7. If a procedure is necessary by Dr. Abdo that will not be preformed here, the patient may be referred to Ferrell Hospital or Harrisburg Medical Center, the patient's choice of.
8. Central Supply will complete the Patient Referral Form and schedule the procedure for Dr. Abdo through the Dr.'s Clinic in Eldorado (618-273-2512, ext. 1722) and the procedure will be scheduled at the hospital of patient choice.
9. The completed Patient Referral Form and appropriate prep (if applicable) is given to the patient in writing. A copy of the Referral Form should be kept by the scheduling person for reference if needed.
10. If the patient will already be gone before the procedure is scheduled, a copy of the appropriate prep (if applicable) will be given to them before they leave from the consult, and the patient will be notified of the date and time of the scheduled procedure by phone. Any questions and/or additional instructions will be given to the patient then.
11. Central Supply personnel will fax the Patient Referral Form and other pertinent information (current medications, lab and radiology reports, etc.) to the Eldorado Clinic. If there is a previous consult by Dr. Abdo, obtain a copy to fax with the other information or have Medical Records fax it to the Eldorado Clinic.
12. The referral is logged.

Treatment Room:

1. A request is made for an outpatient treatment from a physician office or clinic (usually by phone) and is directed to the:
   a. Utilization Review (UR) Department, Monday through Friday, 8:00 am - 3:30 p.m.
   b. On weekends, holidays, and when no one is available in the UR department, the request is directed to the Emergency Room (ER) Nurse.
2. If a medication is to be given and the patient is not bringing their own medication we must know the day before so that we can make sure that the drug is available. ***(We do not always have the drug requested in stock.)*** **If the patient is symptomatic and must have the medication the same day, we still need to be called so that we can tell you whether the drug is available. If it is not, the patient may have to go elsewhere for that dose.**
3. The following information will be needed at the time of the request:
   a. Patient name and phone number where they can be reached
   b. Patient diagnosis - will need code for billing

c. Type of treatment ordered (medication, lab work, PAC flush, etc.)

d. Patient physician on **our** active medical staff at Hardin County General Hospital

e. Allergies (if medication is ordered)

f. Type of Pay:

A. Commercial Insurance (CI) - Need to know if they have a Pharmacy Card if medication is required. If we will be furnishing the medication we must call the hospital pharmacy to see if the drug is available. We may need to pre-cert the treatment ordered.

B. Public Aide (DPA) - Patient must get a prescription to take to an outside pharmacy and bring the medication with them.

C. Medicare - We must call the hospital Pharmacy to see if the drug is available.

g. Written order or prescription needs to be FAXED to 618-285-2700 - Attention UR or ER Department (depending on which department you talked to) The original order needs to be brought to the hospital by the patient or mailed to Hardin County General Hospital, Medical Records Department, POB 2467, 6 Ferrell Road, Rosiclare, IL 62982.

4. The department taking the order will call the hospital staff physician requested to see if He/she accepts the patient and order.

5. When we are supplying the drug tell the patient that we will call them when the drug will be available and schedule an appropriate time for them to come to the hospital.

6. The following departments are to be notified when a request is received for outpatient treatment:

a) Pharmacy - if there is a medication request and we are going to be providing it. They will also need a copy of the order/script.

b) ER - they will need a copy of the order/script

c) Lab - if there are any orders for lab work indicated. ER will make out a Lab requisition for the patient to bring with them with instructions to Lab as to what to do with the results (e.g., Fax results to physician office, call results, give results to ER, etc.)

d) Medical Records - A copy of the order/script is to be given to Medical Records. The original order will be forwarded to Medical Records when it arrives.

7. The green Outpatient Treatment Room Record is used to document the treatment ordered. It is to be completely filled out as applicable.

8. All OP Treatments done in ER are logged in the book provided. UR logs all referrals through their office in the Outpatient Treatment Request Log.

9. The accepting physician on our staff will countersign the order after it is written as a V.O. or T.O. by the nurse.

VI. DOCUMENTATION

Charges are documented and sent to the Business Office for billing.