

LMC Position Paper (PP1/05)

Referral Forms

The principles

- The needs of the patient are paramount
- The purpose of the referral letter is to provide information to assist the secondary provider to deliver appropriate medical care to the individual patient
- All care providers are responsible for their own administrative systems

The problems

Over recent years more and more hospital departments are designing forms that they expect GPs to use when referring patients to consultants or GPsWSIs.

The quality of information asked for on the forms is less informative for its primary purpose than a good quality traditional referral.

The forms do not integrate with GP IT systems, and so are lengthy to complete, prone to illegibility, and less likely to pass on accurate past medical history or current medication. Easily forgotten details such as allergies are also easily omitted. There is no record of the details of the referral on the GP system for medicolegal purposes.

The large numbers of hospital departments with differing requirements have resulted in a large number of forms for secretaries to keep, find, and photocopy when they run out.

GPs referring using a traditional letter often find their referral rejected.

Tick-box forms trivialise the complexities of referral decisions, obscure nuances of the English language, degrade personal GP/consultant relationships, and de-professionalize general practice.

Individual referral forms will be incompatible with any 'Choose and Book' initiative.

Reasons for the forms

On discussion with secondary care managers the first reason given for the forms is to allow the collection of data for audit purposes.

Occasionally it is mentioned that some GPs write poor quality letters and the forms encourage certain important details to be provided.

Some GPs, particularly those with low levels of IT use, find them convenient.

Discussion

It appears that managers in the secondary sector have firmly placed the cart before the horse, and subjugated the clinical needs to the administrative.

If audit needs to be done it is the responsibility of the secondary provider to collect the data, general practice has enough audit requirements of its own.

If letters from GPs are of poor quality, this should be addressed through clinical governance channels rather than by blanket measures such as standardized referral forms.

We would expect referral letters, in addition to demographic data, to contain an assessment of urgency, description of the clinical problem and examination findings, relevant test results, past medical history, drug history, allergies, and details of treatments already tried.

Secondary care providers have a duty of care to patients referred to them, and this starts from the moment that they are made aware of the referral. For a provider to refuse to see a patient on the grounds that the referral was not made on a particular form is ethically unacceptable.

Recommendation

- That Secondary care providers are welcome to distribute standardised referral forms if they wish.
- GPs are encouraged to use whichever method of referral they feel will best provide an exchange of clinical information and ideas between the consulting doctors.
- Patients being referred on traditional referral letters must on no occasions be discriminated against.
- The collection of audit data remains the responsibility of the organisation carrying out the audit.
- GPs consistently providing inadequate referral letters or inappropriate referrals should be helped improve their practice through clinical governance procedures.

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(From an original paper by The Northern Lincolnshire and East Yorkshire LMCs)