To establish guidelines for the tracking of patients referred for specialty care

1. As referrals are made to specialists, a referral will be entered into EHR including the date, patient name, referring provider, referral specialty, reason for referral and appointment date and time.

2. Provider will send a clinical message to the medical secretary with the referral attached.
   a. If Provider sending the referral is not the PMD, clinical message should be sent to PMD.

3. Secretary will set up appointment and/or if the family is making their own appointment the referral is then finalized and sent via clinical message to the PMD’s medical assistant as well as the referral department.

4. The medical assistant will then follow up with the family within one week, if we make the appointment and two weeks if the patient family has opted to make the appointment, to see if the appointment was attended or made and document in a note in the EHR. Notes will be left as preliminary until confirmation that the patient has been seen or after two attempts to contact the family has been made unsuccessfully within a two week period of the appointment date.

5. When the report or correspondence from the referral doctor is received, this date will be recorded as a note in the EHR as a means of tracking patient compliance and all non affiliated provider reports will be scanned into the patient chart. If the report comes electronically the provider will save the note in the patient chart and notify his or her medical assistant.

6. The medical assistant for the appropriate provider will monitor delinquent orders without results in order to follow-up on correspondence not received or patients who fail to keep their appointments. The medical assistant will have the medical secretary for the care team reschedule missed or canceled appointments and inform the provider if the patient is not compliant in keeping referral appointments. At which time a letter will be sent by the provider to the family.

7. Provider will inquire at well child visits as to any self made referrals and document those in the EHR. Information about the specialist should be obtained and follow up by the medical assistant for a report should be documented in the EHR.

Signed By ___________________________________________________ Date:____________________

Supervisor Signature___________________________________________ Date:____________________

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