SERVICE COORDINATION WITH GENERAL PRACTICE - SMALL GRANTS

CASE STUDY: FMPPCP General Practice Best Practice Project

1. Description of project – key activities undertaken in the project & key results of those activities.

Project Description

- A six month project to identify best practice service coordination e-referral pathways between general practice and primary health care services.
- When these pathways have been agreed and documented they will be built into the Seamless Access System protocol for use with all participating agencies identified above.
- The project will involve:
  - the Mornington Peninsula Division of General Practice,
  - up to 5 - 10 general practitioners who commonly refer to
  - the Peninsula Health R.A.P.S (Rehabilitation, Aged & Palliative Care Service) Access Unit (PHRAPSAU). The Access Unit is operated by MEACAS (a participating member of the FMP PCP Seamless Access System).
  - Up to 5 consumer representatives to provide feedback on the effectiveness and efficiency of the protocol that is developed from a consumer/carer perspective.

Progress of the project to date includes:

- mapping existing referral process for both Lang Park Medical Centre and the RAPS Access Unit – see Attachment A
- application/registration PKI digital certificates
- support and training for agencies in use of PKI certificates
- involvement Peninsula Health I/T department in loading software on to RAPS Access Unit systems so that they become involved in the project
- re-development of the FMPPCP Seamless Access System Protocol to emphasise service coordination between general practice and SAS system participants (See Attachment B)
- Mt Eliza ACAS liaising with consumer group to provide feedback on electronic referral processes
- development of the FMPPCP E-Referral Protocol (See Attachment B)
- training and support for project participants in using the protocol
- testing the protocol

2. Using the RE-AIM framework to guide your reflection, please describe the successes and lessons of your project.

The major learning is that it takes a lot of time, training and support to assist an agency to apply for and be registered, and then load and use the PKI software which enables fully encrypted emails between registered PKI certificate holders.

The major success of the project so far has been the development of an e-referral protocol which is suited to wider use across Victoria.

As well as this, the FMPPCP Seamless Access System (SAS system) protocol has been re-focussed (see Attachment B) to emphasise service coordination between general practice and SAS system participants (see below).

REACH - Definition: The absolute number, proportion, and representative ness of individuals who are willing to participate in a given initiative

EG. Some projects are based within a single practice or group of practices and focus on use of a tool (form, directory, protocol).
Key questions might be:
- How many individuals in the practice(s) participated in the project? How many didn't?
- Did you conduct the project with the number of practices you aimed to reach?

We aimed to reach between 5 – 10 general practitioners in this project. For reasons outlined below this has not yet occurred.

Although this was funded as a six month project, in fact it is still in the early development stage. The reason for this is that in the first instance the project has concentrated on developing e-referral pathways between general practice and the RAPS Access Unit. Even at this stage, up to 7 or eight months later the project is still in the development stage. The reason for this is that it has taken a great deal of time to set up the technology with the PKI digital certificates which enable secure emails to be shared between PKI registered participants. Even at this stage we are still running into hitches.

The current hold up in testing the protocol, i.e., exchanging dummy PKI encrypted e-referrals, has been found to lie in the current version of Medical Director, which can only exchange them between Medical Director software. Medical Director cannot send and receive between other software yet. This is being addressed in the next generation of Medical Director, due out soon, very possibly in March.

EFFECTIVENESS – Definition: The impact of an intervention on important outcomes, including potential negative effects, quality of life, and economic outcomes.

Within the RE-AIM framework, efficacy or effectiveness is measured at the level of the individual and is reflective of the success of an intervention when implemented as per intervention guidelines under optimal conditions or in real-world situations, respectively.

Some projects are based within a single practice or group of practices and focus on use of a tool (form, directory, protocol).
Key questions might be:

- Did the participants use the Referral Form/Service Directory/Feedback form? *Why or why didn't they use it?*
- Is there anything about the support etc that you provided that worked particularly well? Anything that proved difficult?

Tony Vivian and the Access Unit have tested the protocol and have established that it does work and works well between non-Medical Director sites. When the hitch in Medical Director is resolved the project participants will encrypt SCTT tools.

Although the time is up all project participants are committed to continuing until the e-referral protocol is operating effectively between general practice and the full FMPPCP Seamless Access System. This has come about through the dedication of all participants, including, significantly the Division of General Practice.

As well as this there is high enthusiasm within the rest of the main players in the Seamless Access System. Our whole FMPPCP Seamless Access System (SAS) participants (10 agencies so far) are in the process of applying for PKI registration so that they can participate in an extended trial of the e-referral system.

ADOPTION - Definition: The absolute number, proportion, and representativeness of settings and intervention agents who are willing to initiate a program.

E.G. Some projects are based within a single practice or group of practices and focus on use of a tool (form, directory, protocol).
Key questions might be:
- How widely do you think use of the tools will be taken up by different practices in the division? Why?
- What proportion of practices do you think are 'ready' to adopt the Service Coordination tools?
- What are the characteristics of these practices? Are their any capacities or characteristics that are 'minimum requirements' to enable implementation to even be attempted?
- Would different types of practices need different strategies to encourage implementation? What sorts of strategies for what sorts of practices?

At this stage, only one general practitioner, Dr John Siemienowicz has participated in the project. There are a number of other GPs who have indicated interest in participating, but Dr Siemienowicz, Executive Director of the Mornington Pen. Div. General Practice and joint manager of the project with FMPPCP, has wanted to ensure that the e-referral protocol actually works well between participating referrers before including more general practitioners in the project.

He has identified a number of general practitioners who have the technological functionality to enable them to participate in the e-referral project.

MT Eliza ACAS has provided a list of general practitioners they receive referrals from. Two further PCP member agencies have provided a list of GPs they regularly send and receive referrals from, suggesting that they be included in the project. This is how we envisage that GP engagement will proceed. Individual general practitioners who refer 'with' SAS system agencies will be 'invited' participate in service coordination, using the SCTT tools and e-referral, where appropriate.

The members of the FMPPCP Seamless Access System

Agencies shown in bold/italics already have implemented use of the SCTT tools and have plans in place for participation in the electronic SAS system, the agencies shown in italics are developing plans to implement use of the SCTT tools, and may participate in the electronic SAS system in the future. It is not necessary to use e-referral to participate in the SAS system itself. To participate in the SAS system it is required that the SCTT tools be used, but they can be faxed or sent electronically.

- ***Brotherhood of St Laurence***
- ***Frankston City Council***
- ***Lang Park Medical Centre***
- ***Morn Pen. Div. Gen. Practice***
- ***Pen. Comm. Health Service***
- ***Peninsula Health***
    - *M.E. ACAS*
    - *Integrated Care Program (Social Work, PENPAC & R.A.D. Team)*
    - *Peninsula Complex Care Program (HARP)*
    - *Age*d Psych.
    - *Primary Health Services - Frankston Community Health Service*
- ***RDNS – Frankston & Rosebud***
- Bunurong Aboriginal Health Service
- *Do Care: Southern*
- *Extended Families Australia*
- Frankston Comm. Support & Info.
- Good Shepherd Youth & Family Services
- IMPACT
- HSSD (Homelessness Service System Development Project)
- *Mental Illness Fellowship Victoria*
- Menzies Inc.
- *Mount Eliza Community Contact*
- *Peninsula Hospice Service*
- *Peninsula Support Service*
- Relationships Australia
- Richmond Fellowship of Victoria
- *SECASA*

- Seniors Pty Ltd
- South Central Migrant Resource Centre
- *Southern. Pen. Community Care*
- *Vision Australia: Southern*
- Woorinyan Employment Service
- Womens Health in the South E
- Wongabeena Assoc.

IMPLEMENTATION - **Definition:** At the setting level, implementation refers to the intervention agents' fidelity to the various elements of an intervention's protocol. This includes consistency of delivery as intended and the time and cost of the intervention.

EG. Some projects are based within a single practice or group of practices and focus on use of a tool (form, directory, protocol).
Key questions might be:

- Were you able to provide support to the practice(s) as you intended? If not, why not?
- Were you able to engage key people and achieve a whole of practice approach? If not, why not?
- Do you know the reasons why individuals did or didn't participate?
- How did the participants use the Referral Form/Service Directory/Feedback form? Eg did they use it consistently/accurately etc? If not, why not?

The PCP project staff, in particularly, Tony Vivian the IM/IT Project Manager for the PCP has provided a high level of support to all the project participants, including the general practitioner involved, so far and the Access Unit Manager and Co-ordinator.

This has included:

- assisting the Access Unit to apply for PKI registration,
- providing training and support in the use of the PKI digital certificates
- facilitating involvement of Peninsula Health's IT department in the PKI installation and operation
- development of the e-referral protocol
- troubleshooting problems that arise in the testing of the protocol

Other general practitioners will become involved in the project when the technical problems have resolved.

MAINTENANCE - **Definition:** The extent to which a program or policy becomes institutionalised or part of the routine organisational practices and policies. At the individual level, maintenance has been defined as the long-term effects of a program on outcomes after 6 or more months after the most recent intervention contact.

Some projects are based within a single practice or group of practices and focus on use of a tool (form, directory, protocol).
Key questions might be:

- What aspects of Service Coordination at the statewide or local level do you think need to be strengthened in order for more practices to use the tools?
- What would be the ideal resources and methods that you'd like to use for 'roll-out' of Service Coordination in more practices?

When the trial and testing of the e-referral protocol has been completed satisfactorily, the protocol will be incorporated into the FMPPCP Seamless Access System Protocol. When this occurs all the FMP PCP Seamless Access System participants will use the protocol in their day to day service coordination work with general practitioners and other primary health care partners.

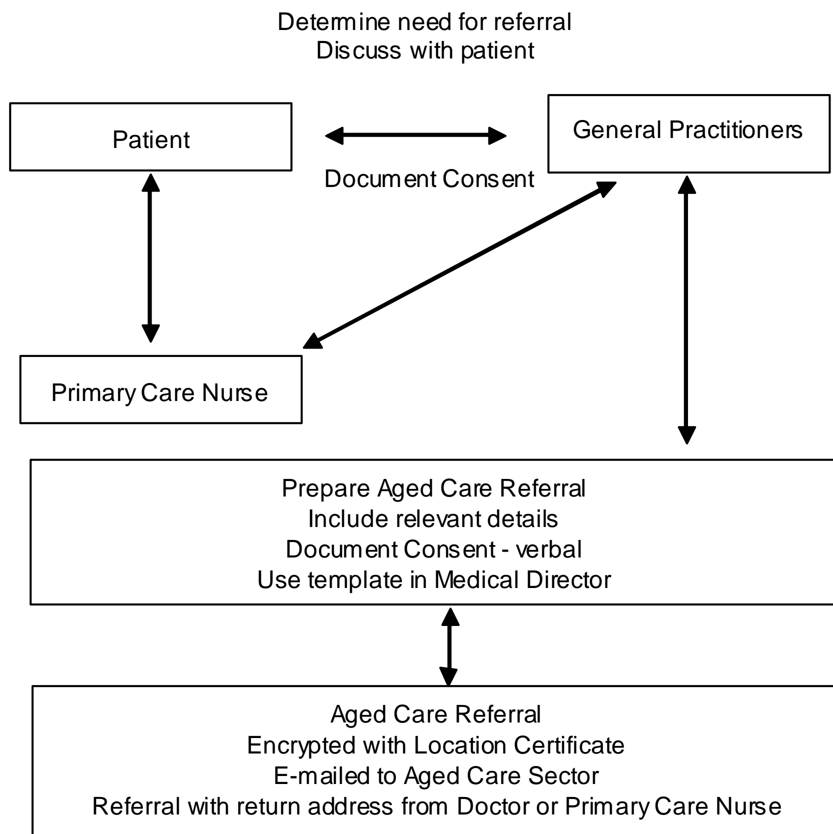
At a statewide level, the time and frustration of applying for and receiving PKI registration needs to be reduced. The technical hitches within Medical Director need to be resolved, so that it can interact with other software programs using PKI registration.

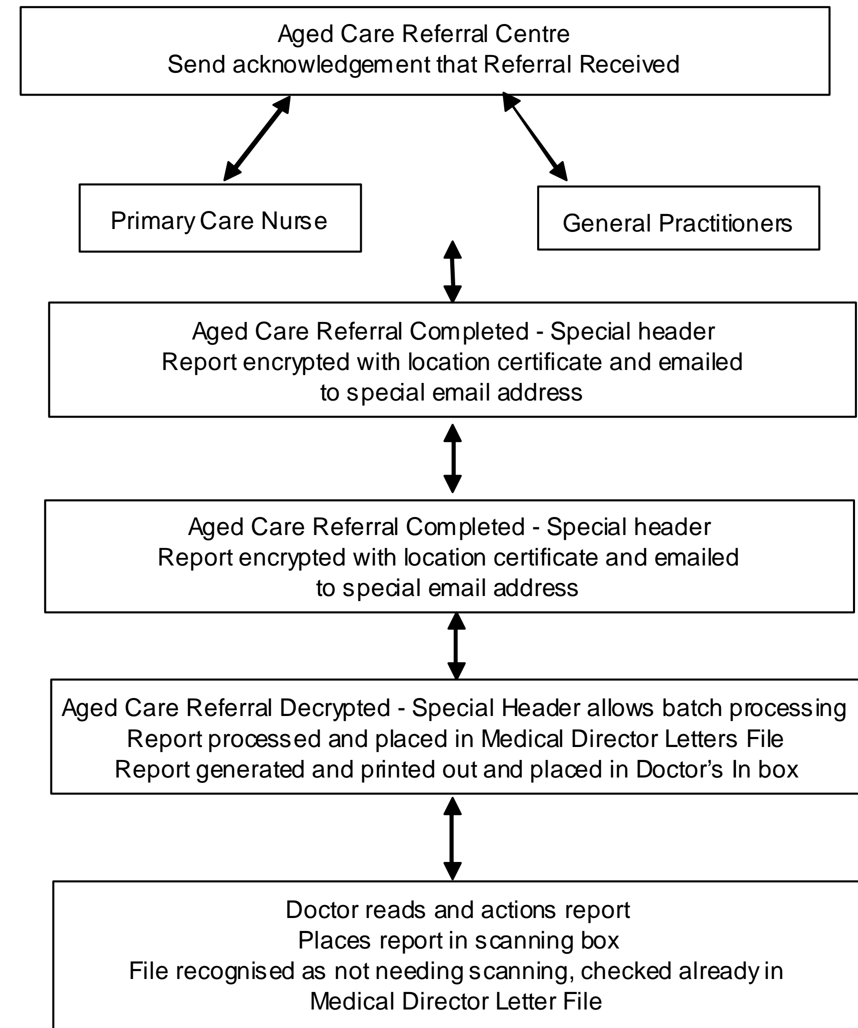
ATTACHMENT A:

Client Pathways of Participating General Practice and Primary Care Agencies

Lang Park Medical Centre

Work flow - Referral to Aged Care Sector





Attachment A contd.

PENINSULA HEALTH

Process Map - ACCESS

- Value Adding

- Non Value Adding

	ACTION pink is Mt Eliza action, yellow is MEACAS, blank is Frankston action	ACESS	ACAS administratio	Assessment Officer	General Practitioner				
1	On receipt of referral, via PKI Eligibility for services is determined	X							
2	Identify any additional information required								
3	Where appropriate, seek from General Practitioner additional input including risks and extent of urgency	X							
4	Determine priority using risk assessment / priority tool	X							
5	Register client with ACAS	X							
6	Provide feedback to the General Practitioner via E-mail that referral has been received and allocated to the ACAS	X							
7	Information sent to the client - confirmation of referral, brochures - ACAS information / its your information	X							
8	Details are entered on the data base and file created								
	GP to notify ACAS of any change of circumstances affecting the response time or assessment process								
9	Client details are entered on the dailies list and forwarded to the ACAS								
10	Referrals are allocated to Assessment officers the following morning								
11	The home assessment is completed								
	Where appropriate, dialogue with GP to clarify findings								
12	A report is generated								
13	The report is forwarded to the General Practitioner via encrypted E-mail								
14	GP Provides feedback to the ACAS via E-mail that report has been received								
15	Ongoing dialogue with GP if case is for review and change of circumstances								
16									
17									
18									

ATTACHMENT B:

SEAMLESS ACCESS SYSTEM

SERVICE COORDINATION PROTOCOL

Participating Organisations:

- **Frankston City Council**
- **Lang Park Medical Centre**
- **Mornington Peninsula Shire Council**
- **Peninsula Community Health Service**
- **Peninsula Health:**
  - **Aged Psychiatry Assessment Team**
  - **Frankston Integrated Health Centre**
  - **Frankston Hospital RAD Team**
  - **Mt Eliza ACAS**
- **Royal District Nursing Service**

Better Access to Services

1.1 Purpose of Protocol

This document forms a voluntary agreement between the signatories to operate within specified guidelines and practices, to achieve improved service outcomes for patients/clients within the geographical boundaries of the Frankston City Council and Mornington Peninsula Shire Council. The Protocol has been developed for the mutual benefit of clients, general practice and primary care member agencies of the Frankston/Mornington Peninsula Primary Care Partnership.

The Protocol is agreed to by participating general practices and primary care organisations. It provides a framework for working collaboratively, utilising the Frankston/Mornington Peninsula Primary Care Partnership's 'Seamless Access System', in order to provide the best possible and consistent services to our patients/clients. The Protocol provides for agreed practices, processes and systems to implement the Better Access To Services policy and framework platform of the Department of Human Services.

The Seamless Access System operating between general practice and other participating primary care organisations will facilitate the development of a 'virtual organisation' by means of utilising a common language and understanding of needs identification processes and by means of utilising common tool templates to perform these functions with. The common language understandings and practices should ensure maximum benefit to patients/clients and efficiency in the operations of general practice and partici-pating primary care organisations..

It is intended that the Seamless Access System will ensure appropriate use of services and coordination of care for patients/clients utilising the services of general practice and participating organisations.

This document sets out practice steps, procedures and policies for practical operation and examples of best practice pathways between general practice and primary care agencies for the processes of initial contact, initial needs identification, referral and a feedback mechanism for the referring provider. Together, the various components of this document form the inter-agency protocol necessary to provide functionally integrated service co-ordination in the south of Melbourne.

1.2 Participating Organisations

Organisations participating in this Protocol Agreement are:

- Brotherhood St Laurence
- Frankston City Council
- Mornington Peninsula Division General Practice
- Mornington Peninsula Shire Council
- Peninsula Community Health Service
- Peninsula Health:
  - *Aged Psychiatry Assessment Team*
  - *Frankston Hospital Integrated Care Program*
  - *Frankston Hospital RAD Team*
  - *Mt Eliza ACAS*
  - *Peninsula Complex Care Program*
- Royal District Nursing Service

These organisations will interact collaboratively with one another, utilising common practices and processes for referral services to common clients who have complex needs

Seamless Access to Services

2. The Seamless Access Process

The Seamless Access System is a multiple entry/single system, allowing patients/clients and carers to:

- enter the system by seeking access at their preferred general practice clinic or primary care agency
- encounter one single system governing access regardless of the clinic or agency they enter
- have assisted referral to other agencies should they want or need to be referred to them
- not have to repeat the information that has been collected from them so far in the process
- have their information collection built on to rather than repeated both between clinics/agencies, *and* between episodes of care.
- have their privacy maintained in accordance with Privacy legislation
- have access to a services gateway to gain information about their health concerns and services available to address them

The Seamless Access Process incorporates a number of steps. It is agreed that any of the participating general practices and primary care organisations could provide a point of contact and referral within this

process. This is an operational model linking services, practices and processes. This will incorporate core elements, which will be consistently implemented by all participating service providers. Core elements include:

- Consumer Information
- Initial Needs Identification
- Profiles
- Summary & Referral
- Consumer Consent
- Care Planning
- Feedback loop to referring provider

Participating clinics and primary care organisations will use these core elements in common to facilitate referrals within the Seamless Access System. Thus, they will become functionally integrated in respect of their referral procedures. Participating clinics and organisations will be responsible for:

- ensuring that they and other clinics/organisations have up to date and accurate information on services provided,
- contact numbers,
- service compatibility,
- eligibility criteria,
- priorities of access,
- waiting-list and response times.

They will also be responsible for providing feedback reports to the referral source about the outcome of the referral:

- patient/client was assessed on ......
- patient/client to be assessed on .....
- we will provide *(Specify service type)* ....
- patient/client has been placed on our waiting list and will be reviewed on ..
- further information is attached.
- we will send you more information by ...
- patient/client was not eligible for our service.
- patient/client was referred to ....
- other

Where possible, general practitioners and primary care service providers will engage in joint planning when a client is to be discharged from hospital and/or has a range of complex needs.

2.1 Seamless Access System Referral Protocol

Aim

The aim of this protocol between general practitioners and service providers within the Service Coordination Group of the FMPPCP is to promote the quality of patient/consumer care and ensure the service system is working effectively by:

- providing streamlined access for consumers to screening, assessment, care planning and service(s),
- achieving functional integration of the referral process,
- providing coordinated support and service to consumers,
- reducing the likelihood of multiple or duplicated consumer assessments,
- promoting the sharing of standardised consumer information through the use of the Statewide Referral (SCTT) Tool Template
- undertaking all activities in a culturally sensitive manner,
- providing accurate, comprehensive, timely and relevant information through the use of the FMPPCP Service Gateway,
- strengthening risk management activities to ensure consumers at risk are identified and appropriately prioritised, and
- promoting improved service delivery by increasing understanding of the specific services provided by all service providers.

Process Objectives

Improving service coordination between general practice and primary health providers is underpinned by the following objectives:

- Patients/clients and carers experience enhanced engagement with services and programs and experience services as being provided in a seamless, coordinated fashion.
- Patients/clients and carers obtain appropriate services and programs in a timely fashion and at convenient locations, irrespective of demographic and social factors (including income, geography, age, gender and cultural background).
- Patients/clients and carers have access to the information they need to genuinely participate in the care they receive and to participate in development of approaches to the management of their health and care information.

To achieve these objectives, it is necessary for general practitioners and service providers to demonstrate

- a commitment to patient/client focused practices where they can receive meaningful assistance by making one approach to the primary care system
- common understanding of service co-ordination processes
- agency and individual roles and responsibilities are clarified so that there is a unified, coordinated approach to practice and the exchange of information between FMP PCP member services and general practitioners
- commitment to coordinated responses to initial needs identification, referral and feedback to referring provider.

Ultimately, all participating general practitioners and member agencies will operate within agreed inter-agency protocols which underpin the following service co-ordination processes:

- Consumer Information
- Initial Needs Identification
- Profiles (where appropriate)
- Summary & Referral
- Consumer Consent
- Care Planning
- Feedback loop to referring provider

Values

Each service provider is committed to:

- respecting consumer rights to informed choice, privacy and confidentiality,
- ensuring consumers are fully informed, and empowered to make decisions and give consent,
- minimising intrusion on consumers when collecting information,
- equity to access to services, based on each service provider's eligibility and priority of access criteria,
- providing services focused on meeting consumers' needs in a culturally relevant manner, and
- respecting each service provider operates within their own organisational and structural arrangements, and simultaneously work within the virtual organisation (FMP PCP).

2.2 Seamless Access: Principles, Practices & Processes

The principles, practices and processes underlying the SAS model were developed and agreed to by signatories to this protocol. They are as shown in the table below:

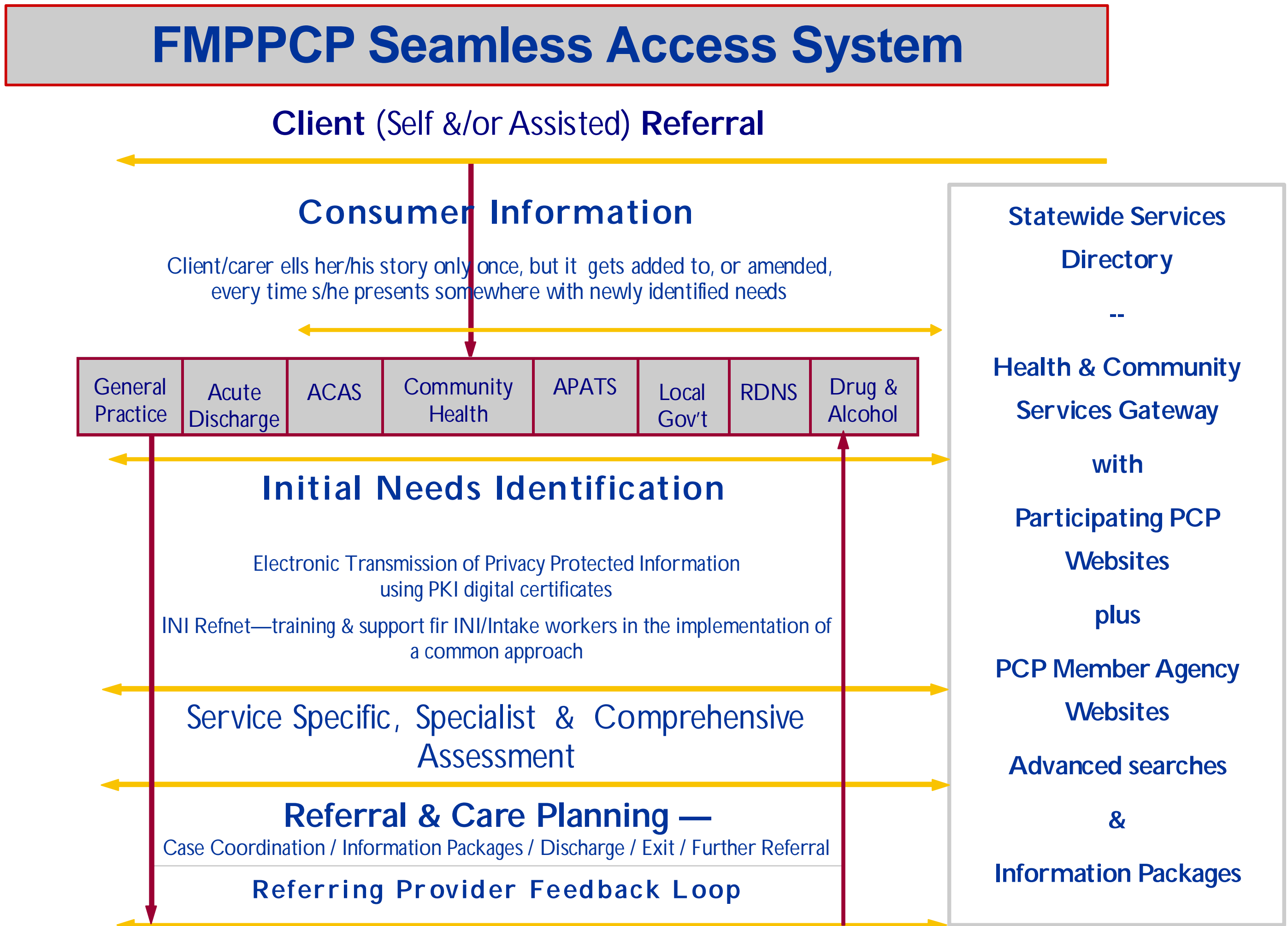
PRINCIPLES	PRACTICES	***PROCESSES***
▪ Consumer focus	• Not having to retell one's story • Client needs determine and drive service processes. • Personal contact is essential. • Recognition of carer pressures • Client needs determined • Gathering accurate and relevant information • Determining priority of need • Awareness of CALD issues • Assessment of need and possible service choices • Agencies' interactions with clients demonstrate that we understand their requirements. • Determination of need from client's perspective • Communication of client's perspective • Good communication opportunities	• initial contact • initial needs identification • assessment • care planning
▪ Confidentiality	• Informed consent • Client privacy and confidentiality is respected • Mandatory reporting • Determination of content to be released • Determination of purpose of information to be released • Use of simple language • Determination of specific release to specific referral points • Professional accountability • Consistency of rights and responsibilities for clients between agencies	• initial contact • initial needs identification • assessment • care planning
▪ Accountability	• We are accountable for the information we present • Professional accountability • Professional competency standards • Meeting standards • Consumer surveys and feedback	• initial contact • initial needs identification • assessment • care planning
▪ Responsiveness	• One phone call produces a clear outcome related to service requested • 24/7 access is required for all services and access to information. • Service coordination • Regular reviews of quality of care • Responsiveness to the needs of the client • Response time to client	• initial contact • initial needs identification • assessment • care planning
▪ Continuous improvement	• Reduced duplication and repetition of information gathering • Processes are simple (i.e. easy to use), effective and efficient for both the client and the agency • Education / Training and development / Workshops • Policies and procedures • Meeting standards • Consumer focus on surveys and feedback • External review of PCP strategy / Progress reports / reviews • Performance indicators / Benchmarks with other PCPs • Regular strategic planning processes	• initial contact • initial needs identification • assessment • care planning
▪ Equitable access	• Development of care plan for clients with complex service needs • Good communication between providers • Determining referral options and where that happens in the process	• initial contact • initial needs identification • assessment/care planning
▪ Cultural and linguistic	• Communications and responses are tailored to client needs • Good communication opportunities whatever language spoken	• initial contact • initial needs identification

appropriateness	• Good communication of service opportunities • Awareness of cultural differences in utilisation of service opportunities	• assessment • care planning
▪ Informed choice	• Use of comprehensive service directory • Information is timely and accurate • Articulating choices to clients • Knowledge of wait times and eligibility criteria/approval • Community education • Client self-determination in relation to choices • Determination of what information client is willing to share • Putting forward short term interim choices for wait-listed clients • One relevant and appropriate point of contact	• initial contact • initial needs identification • assessment • care planning
▪ Timely service provision	• Efficient coordination of services provided • Knowledge of waiting list times • Identified contact point whilst waiting for service • Identifying priority of need incorporated in policy/procedures • Regular reviews of quality of care and working towards improved response times • Efficient and effective resource management	• initial contact • initial needs identification • assessment • care planning
▪ Holistic approach	• Identifying who the clients are (consumer and/or carer) • Informing clients and carers about their rights and responsibilities	• initial contact • initial needs identification • assessment • care planning

2.3 Better Access to Services Within the Seamless Access System: The SAS Model

A Service Co-ordination Flow Chart, based on the multiple points of entry into the service system shown in the SAS Model below, has been developed. Under the Protocol Agreement for the Seamless Access System general practitioners and PCP member agencies will become “functionally integrated”, in that they retain their organisational autonomy, while agreeing to conduct particular referral functions in a common way. Enhancing the flow of information between services and between general practitioners, service providers and patients/ clients/carers, is fundamental to developing functional integration.

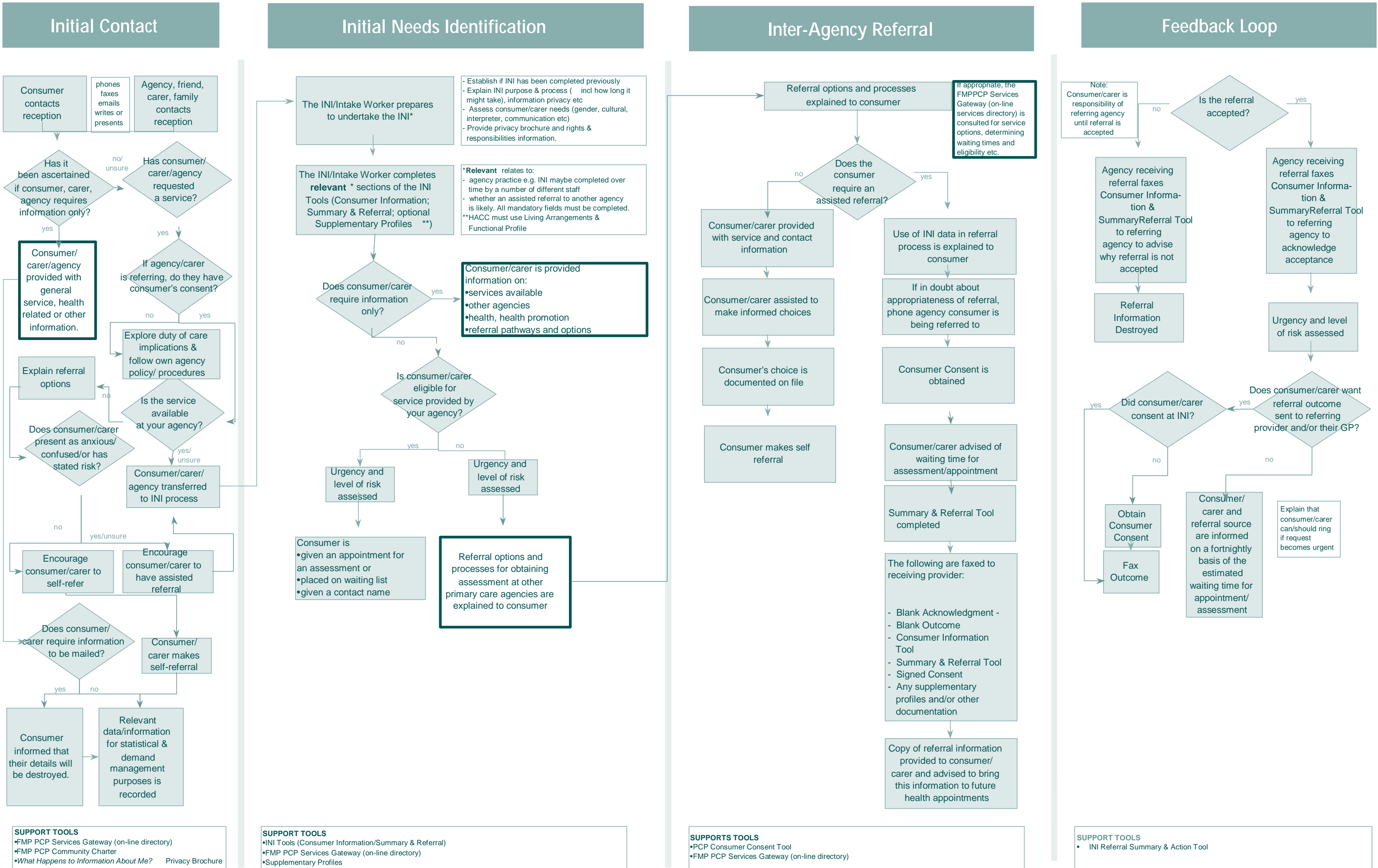
The following diagram depicts FMP PCP’s service co-ordination flow chart of common referral functions.



Service Coordination Flow Chart

A Guide to Conducting the Service Coordination Processes of Initial Contact, Initial Needs Identification, Referral & Feedback Loop

This flow chart is intended as a guide only. The various practices should be conducted at some point but in recognition that each agency is different, these practices may not occur in the linear way in which they appear on the flow chart



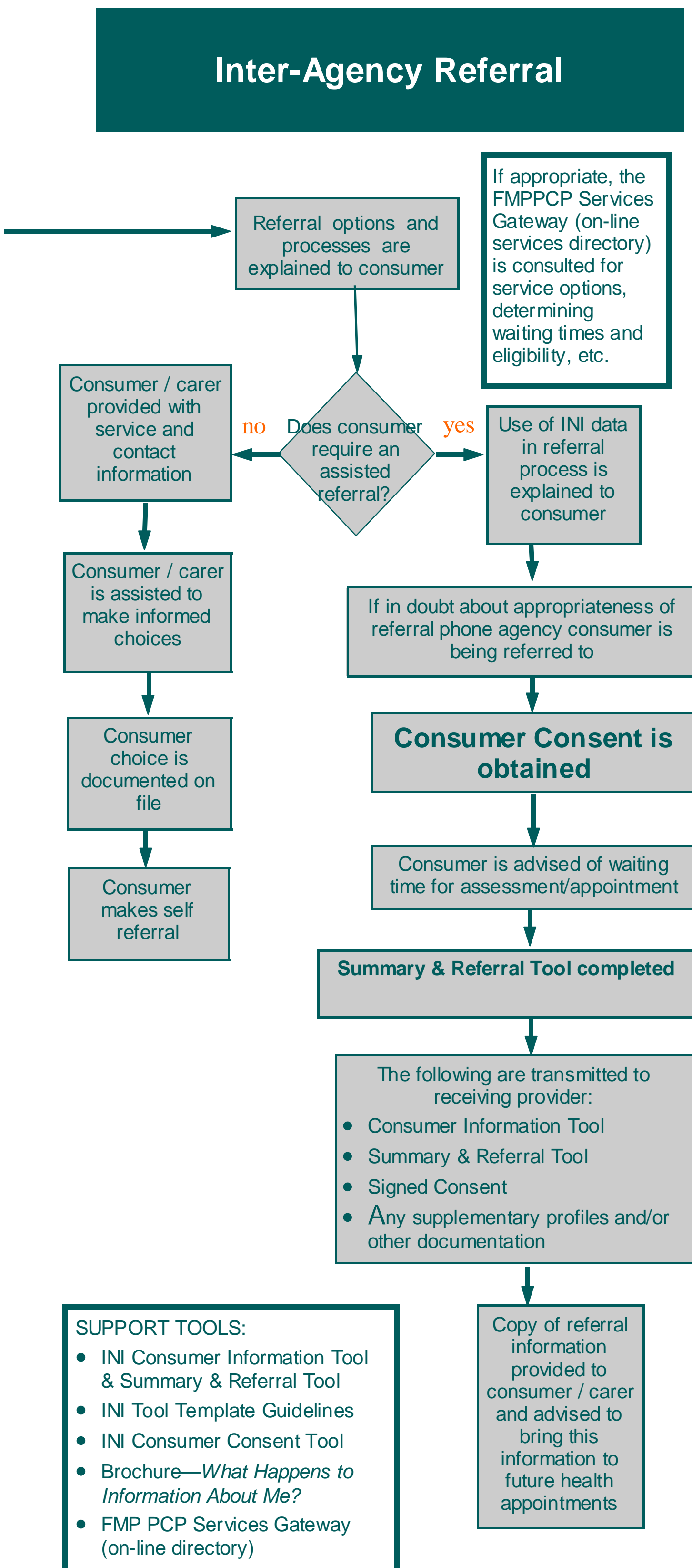
Service Delivery

DELINEATES PRACTICES WHERE FMPPCP SERVICES GATEWAY SHOULD BE USED

8. Making a Referral

This Section assumes that the INI Tools have been completed (see previous section). It covers procedures for actuating a referral.

8.1 Inter Agency Referral – 'at a glance'



Referral is the transmission of personal and/or health information relating to an individual from one service provider(s) to another service provider(s) - with the individual's consent and for the purpose of care or treatment. A referral may be assisted by a service provider, or the consumer may self-refer.

Key Components

The key components of referral are

- Explaining referral options and process to consumer
- Completing the mandatory data fields in the INI tools (consumer information and summary and referral), including risk assessment
- Obtaining and documenting consumer consent
- Providing referral information to consumer and receiving agency
- Acceptance of the referral
- Acknowledging referral
- Providing feedback on the outcome of the referral, to the referring agency, by the receiving agency.

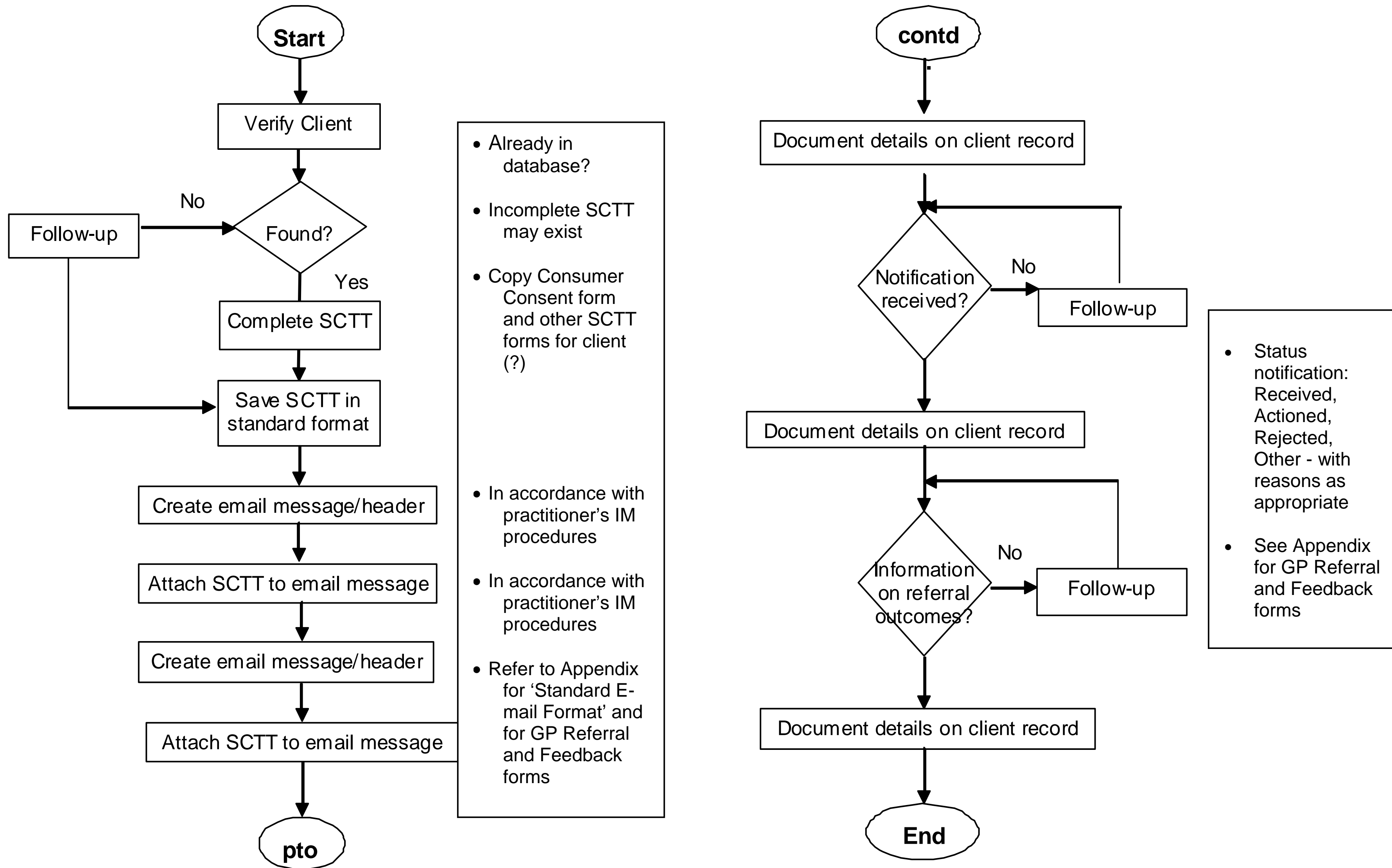
Practice Standards

Agencies will provide

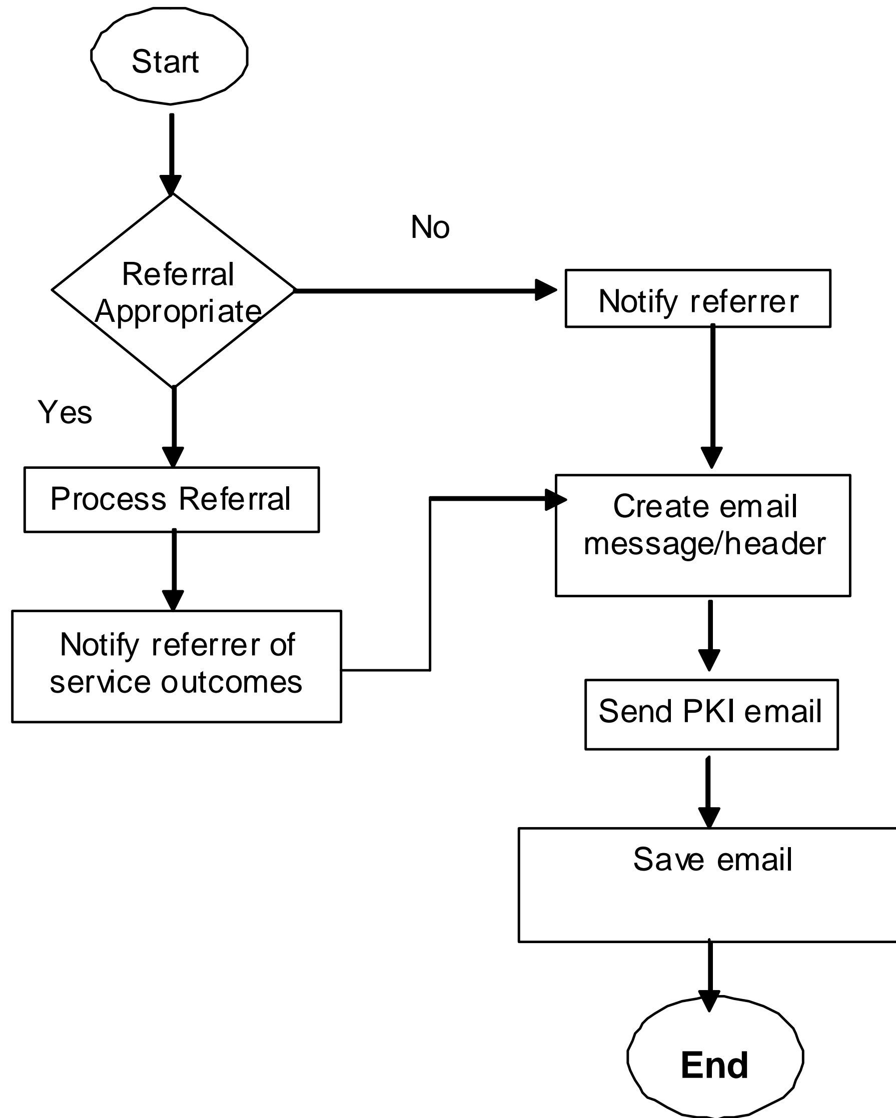
- a functionally integrated referral process which reduces duplication of assessment and the need for consumers to repeat information
- streamlined access for consumers to screening, assessment, care planning
- enhanced risk management and prioritisation activities which are consumer focused
- streamlined processes for self-referral and assisted referrals.

9. Electronic Referral

The following electronic referral protocol is to be used by general practitioners and participants in the Seamless Access System when sending and receiving referral information electronically.



RECEIVING CLIENT REFERRALS



E-Referral Appendix

STANDARD E-MAIL FORMAT[1]

Overview:

This proposed standard has been developed to ensure that participants in the GP Best Practice Project have a common protocol for e-mail referrals.

Scope:

This standard covers the contents of the e-mail header, text within the body of the e-mail and the naming convention of SCTT form attachments.

E-mail Subject Header

As e-mail subject headers are not encrypted under PKI, ensure you do not use any personal client information or references that might identify the client.

Participants in this trial may wish to adopt a standard means of easily identify from the subject header the type of message, the author and the ultimate recipient of the referral.

Naming convention for inclusion in the subject header of e-mail messages:

Prefix:	**With type of communication:**
R	Referral
L	Letter
N	Note
T	Test

Then:	
<1> character	Dash (**-**)
<2> characters	Initials of **Author**
<6> characters	Date (**ddmmyy**)
<2> characters	Initials of **Recipient**

Example:	**R-JS161203JM**
Denotes:	Referral sent by John Siemienowicz on the 16th December 2003 to Judi McKee.

<u>E-mail Attachments</u>

E-mail attachments can be saved in MS Word97/2000 that need to be installed as templates into the MS Office directory of the referrer's PC.

Most clinical software programs use either RTF (e.g. Medical Director's build in word processor) or MS Word format, often with a link to MS Word.

Rich Text Format (RTF) is a file format that allows you to exchange text files between different word processors in different operating systems. It is not expected that this situation will be met in this project, though it might be a worthwhile exercise for some dummy referrals to be saved in this format to test this method of exchanging RTF attachments.

Medico-Legal Obligations

If you are free-writing text into the body of the e-mail, ensure that you have the appropriate documentation within your medical record.

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[1] This proposed format is adapted from the SEPIX Project – Communication Protocols, Dandenong and District Division of General Practice 2002

GP Referral

<<Miscellaneous:Date>>

To <<Addressee:Name>>
<<Addressee:Address 1>>
<<Addressee:Address 2>>
<<Addressee:City>> <<Addressee:Postcode>>

Ph: <<Addressee:Phone>>
Fax: <<Addressee:Fax>>

From: <<Doctor:Name>>
<<Practice:Name>>
<<Practice:Address>>

Ph: <<Practice:Phone>>
Fax: <<Practice:Fax>>
Email: <<Doctor:E-mail>>

Re: <<Patient Demographics:Full Name>> **Patient Record No:** <<Patient Demographics:Record Number>>
DOB: <<Patient Demographics:DOB>>

Reason for referral:
<<Reason for patient referral>>

Requested Priority: **<<Requested Priority?>>**

Attachments: Summary and Referral
Consumer Information
Consumer Consent

Referral Feedback to GP

From: <<Addressee:Name>>
Date: ____ / ____ / ____

Dear GP,

Thank you for your referral. The following action has been taken. Please contact us for any extra information.

- ☐ Client was assessed on .... *(date)* ☐ Client to be assessed on .... *(date)*
- ☐ We will provide *(Specify service type)* .... starting .... *(date)*
- ☐ Client has been placed on our waiting list and will be reviewed on .... *(date)*
- ☐ Further information is attached. ☐ We will send you more information by .... *(date)*
- ☐ Client was not eligible for our service. ☐ Client was referred to .... *(name)*
- ☐ Other ....

....

Agency / Worker Contact Details

Name: .... ***Role / Position:*** ....

Phone .... **Fax***:* ....

Email: ....

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