POLICY AND PROCEDURE

FOLLOW-UP/INTERNAL TRACKING/REFERRAL

Appropriate follow-up measures should be taken to ensure continuity of care for:

1. Patients who have abnormal test results
2. Patients who have been referred to other providers
3. Patients who have missed return appointments
4. Patients who transfer to the health center from another health care provider must be screened by the health center protocols and minimal standards of care must be met as outlined in the policy and procedures. (The health center may accept documented normal results of screening tests done within the periodicity according to the specific program guidelines).
5. Patients who are pregnant and request services other than prenatal care must be asked if they have a designated prenatal care provider and if prenatal care has been initiated. This information must be documented in the medical record. If the patient does not have a designated prenatal care provider, the health center staff must assist the patient in accessing prenatal care. These efforts must also be documented in the medical record.

Documentation of all return appointments and contacts made or attempted must be in patient’s medical records.

“No Show” should be documented in the medical record when a patient is noncompliant in keeping appointments.

Telephone calls made to or from the patient or the physician regarding the patient’s care should be documented in the patient’s medical record. This documentation should include:

1. The reason for the call
2. Any problems discussed by the patient/physician
3. Any action taken and advice or instructions given
4. The date and time of the call should be included as well

The specific time frames utilized when providing follow-up will be determined by the professional who initiated the referral, unless further defined by federal or state guidelines or services protocols, and as indicated by the urgency of the situation. (Specific guidelines for abnormal laboratory/radiology follow-up are found at the end of this section).

INTERNAL TRACKING

To ensure appropriate follow-up, all laboratory tests and screenings, i.e., mammograms and Pap tests, that are sent outside the agency for interpretation shall be reviewed, initialed and dated upon return to the health center by a nurse and a provider before it is filed in the patient’s medical record.
Internal Tracking systems must be developed to ensure that emergency, urgent and essential referrals, appointments and return appointments to the health center are made and kept. This system may either be electronic or hard copy. A tracking system will help to keep the timeline for the patient’s condition and achievement of expected outcomes. It will satisfy patient management and needs by avoiding letting patients “slip through the cracks” or stopping short of completing the patient care cycle.

The system will make sure that problems and care are documented and resolved. Mechanisms for follow-up must be sensitive to a patient’s concern for confidentiality and privacy and must be discussed with the patient. An agreed on method for reaching the patient must be determined and noted in the medical record.

A “Tickler File” is one type of internal tracking mechanism. A Tickler is a memorandum book or file that aids in coordinating the patient’s care through the problem management and corrective action tracking. The Tickler helps to monitor the patient’s course successfully. It is easily managed, flexible and may be customized for specific problems.

**GUIDELINES FOR LABORATORY/RADIOLOGY FOLLOW-UP**

Follow-up on all abnormal laboratory or radiology results are expected. **Patients should be notified within 10 working days** from the health center receiving report of the abnormal result.

Staff shall make a minimum of three attempts to notify patients of abnormal laboratory or radiology tests as follows:

1. Initial contact may be made by telephone if the number is available and patient has permitted home contact.

2. The second contact should be a regular mailed letter with directions for the patient to contact the health center for follow-up.

3. The third should be a certified or registered letter with directions for the patient to contact the health center for follow-up.

4. If the patient cannot be contacted by the above measures, a home visit is strongly recommended for results that are potentially life threatening.

5. If after three attempts are made with no response or three appointments are made and not kept by the patient, the health center provider should document in the chart that the patient is lost to follow-up care.

6. When the patient is referred to an outside medical provider, the nurse will follow-up with the private provider to assure the results are conveyed to the patient. Exception to this will be the Cancer Program’s follow-up guidelines. See the [Cancer Screening/Follow-up Section](#) for specific requirements.
Note: For particular conditions such as abnormal Pap tests, mammograms, newborn screening, and communicable diseases, i.e., TB, HIV, and Hepatitis B, see section program guidelines for required follow-up.

REFERRALS

Referrals are made to assist patients in obtaining services not available on-site. The health center may not coerce patients to undergo any consultation or procedure unwillingly. Referrals may be recommended, arranged for, facilitated and/or paid for by the health center. When the provider or policy and procedures indicate that a referral is recommended, the obligation of the health center is to recommend that the patient seek care beyond the capability of the health center. Documentation in the medical record should reflect that the recommendation was made that the patient seeks further care. It is always appropriate to assist the patient in finding a provider and payment source. The significance of the problem will determine whether a referral is an emergency referral, urgent referral, an essential referral, and a discretionary or nonessential referral.

- **Emergency** – required when a patient’s life is in immediate danger.
- **Urgent** – required when a patient’s condition or problem needs immediate attention, but the condition is not thought to be immediately life threatening.
- **Essential** – required when a patient’s condition or problem needs further attention, but waiting for an appointment for the care is either not a problem, or is appropriate.
- **Discretionary or Nonessential** – those that would benefit the patient, but for which the patient should or could take the initiative.

Written documentation of the outcome and follow-up of an emergency, urgent or essential referral must be obtained. If the patient refuses this level of referral, documentation in the patient’s record is essential. Documentation of the patient’s history regarding follow-up with discretionary or nonessential referrals is essential.

Patients who are participants in managed care payer systems, such as Health Maintenance Organizations (HMOs) or Medicaid Managed Care may be restricted to certain providers or limitations when needing specialist care. An individual should not be referred to a specialist without knowing whether the primary provider’s authorization is required.

Examples of recommended referrals include: dental referral for children and pregnant women; gynecology referral for women with prenatal Diethylstilbestrol-DES exposure; physician referral for age appropriate adults to obtain colonoscopy, sigmoidoscopy, vision and hearing assessment (beyond the capability of the health center).

Examples of referrals for which the health center may pay include: physician referral for child with acute condition in need of diagnosis and treatment (first visit); referral for woman who wants an FDA approved contraceptive not available on site; referral of women with an IUD and suspected pelvic inflammatory disease or positive pregnancy test; women with abnormal mammogram or Pap test requiring further diagnosis or treatment.