MINISTRY OF HEALTH
JAMAICA

POLICY AND PROCEDURE MANUAL FOR THE REFERRAL AND TRANSFER OF PATIENTS

Revised 2016

REFERRAL AND TRANSFER OF PATIENTS

POLICIES AND PROCEDURES MANUAL

Ministry of Health
Jamaica

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1.
INTRODUCTION

1.1

RATIONALE FOR THE REFERRAL SYSTEM

Referrals and counter-referrals facilitate access to different levels of care and different health institutions to ensure comprehensive care covering the full range of health care services: promotion, prevention, early diagnosis, treatment, rehabilitation, palliative care, and support for self–management of chronic conditions.

MINISTRY OF HEALTH, JAMAICA

Vision:
Healthy Population, Healthy Environment

Mission:
To ensure the provision of accessible quality health services and to promote healthy lifestyles.

There is a bi-directional relationship in referrals among Primary, Secondary and Tertiary Care; as while most referrals take place from primary upwards, there are occasions when there will be referrals from tertiary or secondary care downwards.

A referral system is essential to ensure access to the range of quality health services that people may need, while at the same time utilizing Primary Health Care as the entry point to the health system where the majority of health needs can be addressed. Compliance with the principles of access, patient referral & transfer will enhance access to quality care and safety when transfers occur.

1.2 PURPOSE OF THE REFERRAL MANUAL

The purpose of the revised manual is to provide guidance for a strengthened referral pathway that ensures efficiency and effectiveness in the use of the available health care resources and delivers the best possible care in order to obtain favorable health outcomes. The Manual forms the framework to facilitate the smooth transfer of patients through the various levels of the health care network, whilst assuring continuity and quality of care by presenting the procedures to be used. It sets the standard for integrated health service delivery mechanisms and the interdependency required for the congruous performance of the system as a whole.

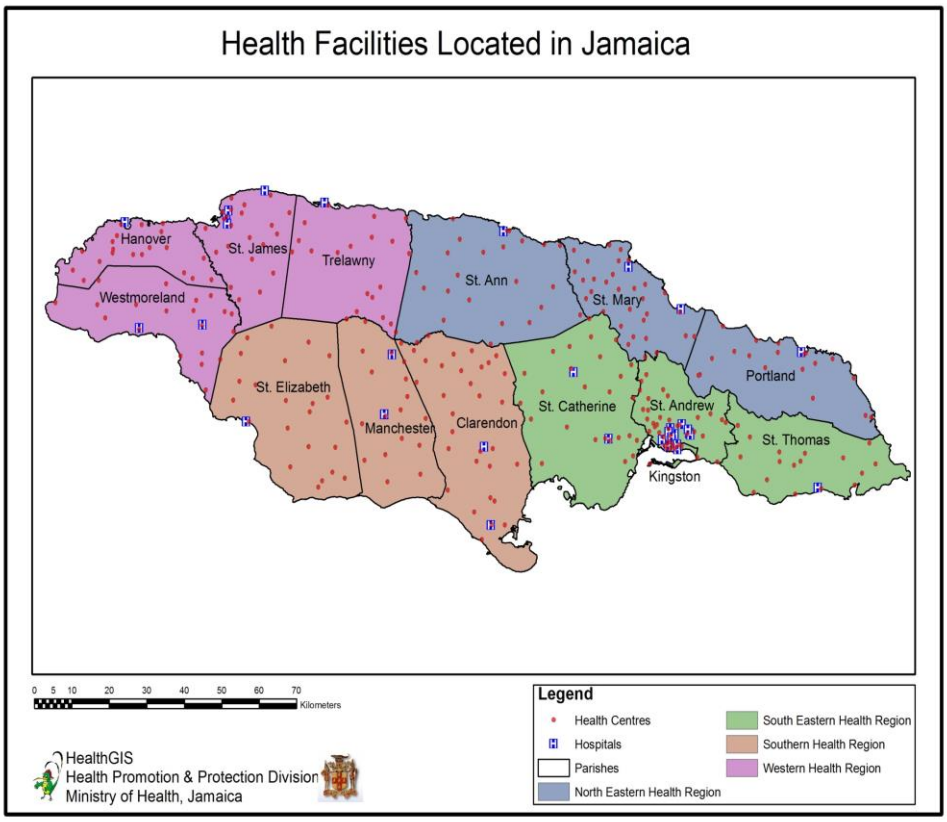
Specifically, the policy and procedures outlined in this manual are designed, inter alia, to:

- ❑ Strengthen coordination and complementation between levels of care, units and institutions in caring for clients.
- ❑ Ensure that clients receive optimal care at the appropriate level.
- ❑ Facilitate optimal and cost-effective use of high specialist facilities such as hospitals.
- ❑ Strengthen peripheral health facilities through feedback which will enhance the skills of the referring doctors by confirming or not confirming diagnoses.
- ❑ Contribute to enhanced utilization of services in the Primary Health Care network by those in need for care.
- ❑ Progressively reduce any unnecessary burden on tertiary and specialist hospitals.

2.
HEALTHCARE DELIVERY IN JAMAICA

Healthcare in Jamaica is offered through the public and private health sectors, providing primary, secondary and tertiary care services. These services are facilitated through a network of hospitals, health centres, and private offices of general practitioners and specialists and are distributed island wide (Fig 1, Appendix 3, 4 & 5).

Fig 1: Distribution of Health Facilities in Jamaica (Public and Private Hospitals, and Public health Centres)



The four Regional Health Authorities (RHAs) [Western (WRHA), North East (NERHA), Southern (SRHA) and South East (SERHA)] are responsible for the management of health service delivery in the public sector, as mandated under the National Health Service Act, 1997. RHAs operate within defined geographic areas (Fig 1).

The Ministry of Health (MOH) is responsible for policy development and monitoring of implementation, while the RHAs are concerned mainly with operations including patient care and public health surveillance. These activities are defined in the Service Level Agreements that the MOH establishes with each RHA. The policy directives of the MOH also govern the private sector.

2.1 PUBLIC HEALTH SECTOR

2.1.1 PRIMARY HEALTH CARE

The Primary Health Care services represent the first level of contact which individuals have with the health system. In the public sector, there are several types or levels of health centres differentiated by staffing, services, and population served.

COMPREHENSIVE HEALTH CENTRE	• population served over 60,000 (located in densly populated areas) • staffing: medical doctors, pharmacist, nurses, technical and administrative staff • services: all mentioned below + for each centre a specific area of specialist care for which it is recognized as the referral in PHC
PARISH HEALTH CENTRE	• population served: 30,000-60,000 persons • staffing: medical doctors, pharmacist, nurses, technical and administrative staff, incl. adminstrative head of the Parish • services: As district health centre services + dental care, mental healthcare, imaging services, specialist medical, paediatric and surgical care • Extended opening times
DISTRICT HEALTH CENTRE	• population served: 30,000-60,000 persons • staffing: full time medical doctor, nurses, pharmacist, technical and administrative staff • services: curative services for communicable and non-communicable diseases, emergency care, laboratory, pharmacy, comprehensive preventative services incl. environmental health, school health, services maternal and child healthcare, health throughout the life cycle
COMMUNITY HEALTH CENTRE	• population served: 10,000-30,000 persons • staffing: visiting doctor, nurse, lab assistant, • services: maternal and child healthcare, first aid, wound dressing, health promotion and eduction, basic lab, community outreach and home visits

OTHER FACILITIES AT THE PRIMARY HEALTH CARE LEVEL

2.1.2 SECONDARY HEALTH CARE

In the public sector, hospital services (Appendix 4) are provided through seventeen (17) general hospitals, six (6) specialist hospitals, and one (1) teaching hospital. Hospitals are classified **A, B, C or S**, according to the level of services offered and the catchment population served. Some hospitals may be staffed by a wider group of specialists and perform a wider array of clinical functions than the baseline B or C; hence, they have been designated B+ and C+.

TYPE S SPECIALIST HOSPITAL

- Single specialist services at national level
- Maternity, paediatrics, psychiatry, pulmonary/chest diseases, oncology and palliative care, and orthopaedic / spinal rehabilitation
- Staffing: highly specialized staff

TYPE A HOSPITAL

- Final referral point
- Broad range of secondary + tertiary care
- Staffing: highly specialized staff
- Bed capacity: 300-500 each

TYPE B HOSPITAL

- Secondary care: in-and outpatient
- All four basic disciplines: General surgery, Internal medicine, paediatrics , gynaecology & obstretics + at least one other discipline such as psychiatric care
- Staffing: incl. specialists in the disciplines mentioned
- Bed capacity: 150-300

TYPE C HOSPITAL

- Basic district hospital: interface with PHC centers at Parish level
- In-and outpatient care : general medicine, maternal-and child care, general surgery and psychiatric care
- Staffing: multiple healthcare professionals including at least one specialist physician (usually a general surgeon)
- Bed capacity: less than 150

2.1.3 SPECIALIST SUPPORT SERVICES

The public health system also includes the following three specialist support service institutions.

THE NATIONAL PUBLIC HEALTH LABORATORY

- Highly specialized, multidisciplinary referral clinical and public health laboratory services incl.:
- Routine biochemistry, haematology, enteric bacteriology and serology
- Public health tests for tuberculosis, malaria, tests for public health surveillance
- Specialised environmental, water, exotic and confirmatory tests

THE NATIONAL BLOOD TRANSFUSION SERVICES

- Specialized blood-banking services incl.:
- Blood donor recruitment and retention
- Blood collection through several satellite collection stations
- Centralized processing of blood and components and highly specialized immunohaematology tests

THE QUARANTINE UNIT

- Services refer to the prevention of introduction of communicable diseases in line with the Quarantine Act of 1951 and the International Health Regulations of 2005 incl.:
- Examining all ships, airplanes, passengers and cargo arriving in Jamaica
- Taking quarantine measures where needed

2.2 PRIVATE HEALTH SECTOR

The private health sector is an important component of the healthcare delivery system. The private healthcare delivery network is presently configured by numerous specialized and general primary care clinics and 11 hospitals (Appendix 5). Private hospitals and specialized clinics are mostly in the urbanized centres while general clinics, important first point of entry to health services, are distributed throughout the country.

3.
NATIONAL REFERRAL SYSTEM

3.1 GUIDING PRINCIPLES

The guiding principles outlined in this section derive from the philosophy of the World Health Assembly resolution on "Health for All"[1] , the Primary Health Care Declaration of Alma-Ata[2] and build upon the new paradigm of Primary Health Care Renewal[3] .These concepts of health and healthcare aim for equitable access to healthcare and embrace the application of a continuum of health states and provision of services; accommodating from high-level wellness to permanent disability and terminal illness. Therefore, a full range of services covering health promotion and protection, disease prevention, diagnosis, treatment, care and rehabilitation, should be provided according the needs of individuals and of communities.

- ❑ At all times, the patient's health and well-being must be the prevailing concern when any referral or transfer is considered.
- ❑ All patients must be encouraged to access the healthcare delivery system through Primary Health Care, which is, the designated first point of entry.
- ❑ Secondary and tertiary care institutions, will advise all self-referred elective patients, with non-urgent primary care conditions to attend the geographically closest primary care facilities through which access to care may be made.
- ❑ All emergencies requiring hospital services should have direct access to hospital services.
- ❑ Economic reasons should not form the basis for transfer or refusal to accept a medically necessary transfer.
- ❑ If a referral is considered unnecessary by the receiving clinician or any other member of the heath team, the matter should be resolved at the senior technical level. Discussions about the necessity of the referral should not involve the patient or relatives; neither shall there be disrespectful remarks or treatment of referring clinicians, as such actions, being unprofessional and unethical, are unacceptable.

1 WHO, 1977. (HFA) WHA 30.43, 19 May 1977
2 WHO, 1978. Alma Ata declaration, 12 September 1978
3 PAHO, 2007. Renewing Primary Health Care in the Americas; a position paper of the Pan American Health Organization/World Health Organization.

3.2 GENERAL PROCEDURES

3.2.1 PREPARING REFERRAL AND TRANSFER

I. A Consultant, Senior Registrar or Doctor In-Charge must first personally assess the nature of the condition and, when possible, stabilize (evaluate and initiate treatment to ensure, within reasonable medical probability, that transfer of a patient will not result in death, loss or serious impairment of body functions, parts, or organs) the patient prior to referral or transfer.

II. Patients should be transferred without delay when it is evident that transfer is medically indicated (the referring facility does not have the capacity to adequately manage a patient) and the receiving hospital has the competency and available bed space. In these cases it is unethical to: deny or delay a transfer to the more equipped hospital; and/or spend time trying to diagnose and dictate treatment by telephone, except where the discussion surrounds patient stabilization prior to transfer.

III. Regional Hospitals should be the first port of consultation for inter-regional referral. The judgment of the referring physician is important however and when it is obvious the service required, will necessitate extra regional consultation, and or is outside the scope of the regional hospital, (e.g. Neurosurgery) valuable time, and resources should not be spent consulting the regional institution, or sending the patient there. In such situations direct consultation to the needed referral centre should be expedited

IV. Prior to transfer, there must be communication between the lead healthcare provider who refers the patient and the consultant or senior resident at the receiving institution.

V. A consultant physician or senior resident at the receiving institution must agree to accept the patient prior to the transfer.

VI. The Doctors in-charge at the referring and receiving facilities should engage the Nursing Services at their respective institutions.

VII. The referring physician should inform the patient or responsible party, as well as document in the patient's medical record the reasons for, risks and likely benefits of transfer.

VIII. Written consent for transfer should be obtained from the patient

...continue on next page

or person legally responsible.

IX. In the case where the patient is unknown or unconscious and there is no next of kin, the consultant making the referral or Senior Medical Officer (SMO) should sign the consent form.

X. Where bed space is a challenge at a higher-level receiving institution:
   a) All efforts must be made by the higher-level institution to identify suitable bed space by discharging or transferring more stable patients to the referring institution or other nearby facility with the capacity to manage the less acutely ill patients.
   b) Where highly specialized beds such as Intensive Care Unit (ICU) or High Dependency Unit (HDU) are not available, the receiving institution and consultant should accept critically ill patients for intermediate care, given superior expertise at the higher-level facility and the potential for better quality service than if the patient remained at the referring institution.
   c) Advice should be provided on care of the patient and possible alternative referral facility identified.

XI. The doctor who refers the patient will ensure that all necessary and appropriate medical summaries with other pertinent records,including diagnostic results (laboratory, radiological studies, ECG, etc.)
accompany the patient.

XII. For each referral, the attending doctor will complete (legibly) the patient Referral Form as approved by the Ministry of Health. ***It is the responsibility of the attending doctor to ensure that all required information is filled on the form.***

- □ **Referral Form A** (Appendix 6) in triplicate for **external referrals only;**
- □ **Referral Form B** (Appendix 7) for internal **referrals within hospitals only.**
- □ Referrals within a health centre require documentation in the patient docket/notes only.

3.2.2 CONDUCTING AND MANAGING THE TRANSFER

The best possible care should be provided during the transfer of a patient between facilities.

I. The patient should be transported in a vehicle that is staffed by suitably trained personnel and contains appropriate equipment.

II. The patient's vital signs should be monitored and adequate support of the cardiovascular and respiratory systems be provided. Appropriate medications, as ordered by the physician or as dictated by medical management protocols, should be used.

III. Communication should be maintained with a physician at the receiving institution during transfer.

IV. Key information include: time of arrival, clinical condition on departure, estimated time of arrival, significant changes in condition during transfer.

V. Adequate records including vital signs and treatment given should be maintained during the transfer and at the hand-over. A copy of the records should be handed over to the receiving team and the other returned to the referring hospital (Senior Medical Officer/Director Nursing Services) for quality assurance follow-up.

VI. The following should obtain upon arrival at the receiving institution:

a) The patient may **by-pass accident & emergency and be admitted directly to the pre-determined ward where the accepting team should be present to receive the patient without delay.** When it cannot be ascertained before hand that the receiving team will be immediately available, it is their responsibility to make immediate arrangements for the handing over of the patient. In the absence of this, the patient should be handed over to the Accident and

Emergency staff when it can be determined beforehand or at the time of arrival that there will be a delay in the handing over process.

b) The responsibility for the patient's care or the custody of the patient is transferred immediately to the receiving institution and consultant / Senior Resident.

c) Upon handing over of the patient, the transfer is considered complete and the transfer team should be immediately released.

d) The required management, including further diagnostic investigations, should then be initiated without delay under the direction of the receiving consultant.

VII. Where there is need for airlift, the Principal Medical Officer, Director, Emergency Disaster Management and Special Services (EDMSS) or the Chief Medical Officer of the Ministry of Health must give concurrence.

VIII. When the patient is being transferred using airlift, the receiving Physician should alert the operations manager at the receiving institution about the transfer so that appropriate transport arrangements, where necessary, can be made expeditiously.

3.2.3 POST-REFERRAL PERIOD

I. For every referral event, there **must** be a **counter-referral or return-referral**,

II. Once the reason for referral has been resolved, the patient must be counter-referred to the originating attending healthcare provider for follow-up,

III. The counter-referral section of the **Patient Referral Form A** must be completed with as much information as necessary for the adequate continuance of care of the patient,

IV. In case of death of the patient, the counter-referral form should be sent to the referring institution and reflect the Cause of Death.

3.3 PRIMARY CARE HEALTH SERVICES

3.3.1 REFERRALS WITHIN PRIMARY CARE

Non-urgent Primary Care Referrals

The public health nurse, registered nurse and midwife may make referrals of a non-urgent nature to the primary care doctor or nurse practitioner on their next visit to the health centre. **Referral Form A** should **only** be completed if the patient is being referred to **another health centre (external referral).** If the referral is internal (within the facility) it is docmented in the docket.

Urgent Primary Care Referrals

A doctor or the nurse practitioner must see patients with conditions of an urgent nature immediately. If a doctor or nurse practitioner is not available, such patients should be immediately referred to the nearest primary care facility where there is an available doctor. **Referral Form A** and other relevant documentation, as previously described, applies.

Specialist Referral at Primary Care

Referrals to specialists are only conducted by primary care doctors. In the specific circumstances, as outlined below, the nurse specialist within the clinic can refer clients, but the primary care doctor must be notified and concur with all referrals:

I. In an emergency situation the Nurse Practitioner refers the patient to the Emergency Department of the nearest Health Facility. All other referrals are to the primary care doctor
II. A Mental Health Nurse can refer patients directly to the Psychiatrist; however, the primary care doctor must be notified of all referrals

III. The Public Health Nurse may refer cases of tuberculosis or suspected tuberculosis directly to the National Chest Hospital Casualty service; however, the primary care doctor must be notified of all referrals
IV. Any staff member with midwifery qualifications can refer directly to the antenatal high-risk specialist clinic within the Primary Care Services and the Secondary care antenatal clinic in the absence of the primary care doctor, who must be notified of all referrals
V. The Dental Nurse or Dental Auxiliary can refer patients to the oral surgeon; but the primary care doctor must be notified of all referrals

Referral Form A should be completed in all cases except for **women who are more than 20 weeks pregnant** with conditions warranting specific antenatal care. In this case, the blue Maternal Record booklet (**NOT the Referral Form A**) should be used when being referred to the hospital.

Upon completion of the specialist review, a counter-referral must be made for continued patient care.

3.3.2 REFERRALS FROM PRIMARY TO SECONDARY OR TERTIARY CARE

Referrals from primary to secondary or tertiary care should chiefly be reserved for specialist and emergency services. However, patients may be referred for investigations not available at the primary care level; as well as for support services such as physiotherapy, nutritional, laboratory, imaging and other diagnostic services.

EMERGENCY SERVICES

In the case of an emergency, any medical professional named above may refer, without delay to the nearest accident and emergency department. If present, the primary care doctor should, if at all possible, stabilize the patient before transfer and complete Referral Form A.

Physiotherapy & Nutrition

Physiotherapy services are usually housed in the secondary or tertiary care setting. Nutrition services are not provided on a full time basis at

all Primary Care Centres. Any Doctor or Nurse Practitioner or Public Health Nurse may refer an adult patient to these services. The doctor or nurse making the referral should:

I. First ascertain that the hospital accepts those referrals;
II. Contact the physiotherapist or nutritionist by phone to obtain an appointment or, provide the patient with sufficient information to make an appointment;
III. Complete Part 1 of Referral Form A, and send it with the patient;
IV. In the case of children, the primary care doctor should make an appropriate referral to the paediatrician.

LABORATORY, IMAGING, AND OTHER DIAGNOSTIC SERVICES

Where these services are not available in a facility, patients may be referred to another or where possible, their samples extracted and sent to these centres for examination. The following are minimum requirements for requesting or transferring patients for laboratory, imaging or other diagnostic examinations:

I. The patient should be advised about the procedures and given specific instructions about preparation by the receiving institution.
II. Informed consent may be required.
III. The standard request forms should be appropriately completed.
IV. A specialist who will advise the referring health professional of results and action to be taken should review all abnormal results.
V. In case of an unstable patient, the relevant specialists at the receiving institution should be appropriately apprised and requested to be on stand-by to review and advise on test results, takeover management of the patient where necessary and for any emergency.

SOCIAL SERVICES

For cases requiring the social support and interventions, appropriate documentation should be made and patient referral should be made under confidential cover to the approved authorities:

I. Cases involving social problems are to be referred to the Social Service Department.

II. Any suspected case of child abuse (sexual/physical) and failure to thrive are to be reported to the Social Service Department and or rape unit as necessary.
III. Any suspected case of child abuse is to be referred for Paediatric Consultation.
IV. Cases of sexual assault in adults are to be referred to the Rape Unit or a Police/Doctor/District Medical Officer is to be summoned where this service exists.

3.4 SECONDARY & TERTIARY HEALTH CARE SERVICES

3.4.1 INTERNAL REFERRALS

These are referrals between specialist areas within the same institution. These include emergency or urgent patient referrals from the accident &emergency department, casualty or admissions requiring multidisciplinary management as well as referrals for less urgent cases (ward or clinic patients).

Under all circumstances:

I. All relevant principles of access, patient referral & transfer apply
II. The patient should be stabilized
III. In cases of emergency or urgent referrals, the senior resident on duty-call shall be alerted immediately of the referral and its nature;
IV. ***Referral Form B*** shall be completed by the senior referring doctor noting the patient's demographic and medical information as well as the physician's professional opinion and recommendations
V. Referrals of a non-urgent nature shall be directed to the relevant outpatient clinic

VI. The patients and or caregivers shall be appropriately advised of the referral, procedures and appointment schedules where applicable
VII. Appropriately documented and timely specialist response(s) or intervention(s)must be made to facilitate continuity of care and or to inform the referring colleagues of the status/progress, diagnosis or professional opinions on the referred patients

3.4.2 EXTERNAL REFERRALS

Referrals may be executed between secondary care institutions or from secondary to tertiary care institutions. These referrals are usually for specialist services, emergency care or investigations that are not available at the referring institution.

In all situations:

I. Referral Form A shall be completed by the referring doctor
II. Direct contact must be made with the specialist of the receiving hospital to obtain concurrence for referral and or to ascertain the earliest appointment date
III. Admitted patients must be transported in appropriate patient transfer vehicles
IV. The patients and or caregivers shall be appropriately advised of the referral, procedures and appointment schedules as applicable
V. Informed consent must be obtained from patients and or care givers (as applicable);
VI. Counter-referrals are to be documented on Referral Form A to facilitate continuity of care and or to inform the referring colleagues of the status/progress, diagnosis or professional opinions on the referred patients;
VII. All other principles of access, patient referral & transfer apply.

3.4.3 SPECIFIC INFORMATION FOR EMERGENCY REFERRALS

Appropriate documentation, including a written record of the problem, treatment given, and patient status at the time of the transfer, **MUST ACCOMPANY THE PATIENT**. Specifically, the following should be provided:

I. Completed Part 1 of ***Referral Form A*** Patient's condition at time of admission to the hospital or Emergency Department
II. Vital signs during patient's stay in the Emergency Department and at the time of departure
III. Treatment rendered, including medications given and route of administration
IV. Laboratory, X-ray, CT Scans and other findings including all films as well as any appropriate laboratory specimens taken
V. Fluids given; by type and volume, including blood transfusions
VI. Name and telephone number of the referring Physician
VII. Name of Physician at the receiving hospital who has accepted the patient for transfer

3.5 PROTOCOLS FOR TRANSFER TO TERTIARY INSTITUTIONS

3.5.1 PROCEDURES FOR EMERGENCIES

At the referring hospital, the patient must first be assessed at the consultant level, resuscitated and stabilized before transfer. The Consultant or Senior Resident at the referring hospital must make direct contact with the Senior Resident or Consultant on duty for the appropriate specialist service at the tertiary hospital (it is inappropriate for the request for transfer to be made by the Intern/Senior House Officer/Junior Resident). The following should be determined:

I. ***Purpose of transfer:*** The specific benefit to be gained by transfer of care (access to specialty or subspecialty consultation or specific investigation, intervention or monitoring).

II. ***Safety of transfer:*** It should be established that the above benefit outweighs the risks inherent in transfer, including that due to disruption of continuity of care by the managing health team and interruption of therapy, and risks.

III. ***Alternatives to Transfer:*** Exploration of possible alternatives to transfer that may be of greater benefit or involve less risk, including accessing similar resources closer to the referring centre.

IV. ***Specifics of Transfer:*** Measures to optimize safety for transfer including stabilizing patient (transfusions, medications), ensuring essential therapy en route (oxygen, airway protection) and appropriate accompanying staff.

V. ***Timelines:*** In order to avoid delays in evaluation and further stabilization of the patient on arrival, the approximate time of arrival of patient (and any change to same) should be clearly communicated to receiving specialist.

VI. ***Intensive Care Requirements:*** If it is determined that the patient may need intensive care, the ICU consultant must be contacted by the receiving consultant prior to the transfer. It is the **responsibility of the receiving specialist team** to make direct contact with ICU staff to confirm bed availability and make arrangements for direct transfer.

IMPORTANT CLINICAL GUIDELINES FOR PATIENT TRANSFER:

- Resuscitation and stabilization of the patient must be completed before transfer
- All patients with a Glasgow Coma Scale (GCS) less than or equal to 8 and or an absent gag and cough reflex must be intubated prior to transfer
- An intubated patient should be accompanied by a transfer team that should include a Doctor or Nurse Anaesthetist trained in airway management

VII. All referrals should be completed using ***Referral Form A*** and all relevant investigations such as laboratory results and diagnostic radiographic investigations must accompany the patient.

3.5.2 REQUIREMENTS FOR SPECIFIC EMERGENCIES

I. *Poly-Trauma Emergencies:* these are patients who present with any combination of fractures, head injury, major vascular injury, facial, chest and/or abdominal injury.All poly-trauma patients should be referred to general surgery at the receiving hospital.
II. Once transfer is deemed necessary the general surgery service at the receiving hospital should accept the patient.
III. Other services will be consulted by the receiving general surgery team as required.
IV. The patient may be transferred directly to the predetermined ward at the tertiary hospital.

At the receiving tertiary hospital, standard clinical management guidelines and procedures must be followed.

Instructions to Relatives in Emergencies

- Relatives should be informed of the transfer;
- Their contact details should be clearly recorded;
- A general consent should be obtained and sent with the patient;
- They should be advised to go to the receiving tertiary hospital as soon as possible.

3.5.3 PROTOCOL FOR ELECTIVE PATIENT TRANSFER TO TERTIARY CARE

- All elective referrals (clinic or for admission) should have prior concurrence with the consultant or senior resident of the specialty discipline.

- The referring consultant should ensure that the patient is sufficiently stable prior to transfer.
- All such transfers should be completed well within regular working hours (before 4 pm).
- All referrals should be done using ***Referral Form A***. A referral letter will suffice for patients from Private Health Sector.
- All relevant investigations already done must be sent with the referral form/letter.
- A counter-referral will be sent to the referring physician by completing and return of Part II of ***Referral Form A***.
- All patients should be accompanied by a relative/guardian who may be required to acquire certain items for treatment that are not immediately available, and to give consent for specific procedures if the patient is a minor or is otherwise incapable of doing so themselves.

3.5.4 PROTOCOL FOR TRANSFER AND ADMISSION TO INTENSIVE CARE UNIT (ICU)

High quality transfer of critically ill patients requiring ICU support improves outcome. The Department of Anaesthesia and Intensive Care is not a primary admitting service and therefore cannot admit patients directly to the Intensive Care Unit (ICU).

I. Direct contact must be made at the Consultant level between the referring and the receiving services and the Consultant of the receiving service contact the ICU Consultant to discuss the case.
II. All transfers are to be taken directly to the predetermined ward where the Admitting Service and Critical Care Team, will take over patient management without delay.
III. The responsibility for the patient should be transferred from the referring to the receiving team upon arrival at the predetermined ward. Arrangements should be made to ensure the immediate return of the referring team with their equipment

to their hospital.

IV. The Critical Care Team will assess the patient immediately to determine severity of the illness and to determine the level of critical care to be offered to the patient.

V. A patient admitted to the ICU will be jointly managed by the Critical Care Team and the Admitting Service, whilst further referrals will be made as necessary.

It should be noted that there can be no guarantee of admission of any transferred patient to the Intensive Care Unit as this depends on many factors including availability of bed space.

3.6 COUNTER-REFERRAL OF PATIENTS

After the necessary treatment is received at the tertiary care level, the patient may be returned to the referring hospital for further treatment, recuperation or rehabilitation. The counter-referral section (Part II ***Referral Form A***) should be completed by the receiving physician and returned with all other relevant documentation to the original referring doctor/facility. This step must be performed to complete the referral cycle between the facilities and ensure continuity of care after resolution at the tertiary level.

3.7 ADDITIONAL PROTOCOLS FOR REFERRAL FLOW

3.7.1 PRIVATE PROVIDERS

I. Private providers may access the MOH system through a Health Center, a Community Hospital and Types C, B, A, or S hospitals.

II. Private providers will adhere to the principles of access, patient

referral & transfer as outlined in this manual.

III. A previous telephone communication and approval for transfer by the appropriate Senior Medical Specialist is absolutely necessary prior to transferring a patient.

IV. Patients referred from a private provider will be treated with the same high standards and quality of care as any other patient and no special privileges will be afforded to the private provider while the patient is under the responsibility of the public system.

V. A counter-referral must be sent to the private provider once the case is resolved.

3.7.2 PROTOCOL FOR TRANSFER USING AIR-LIFT

There are circumstances under which emergency airlift is required. Should that be considered, the following obtains:

I. The consultant, Senior Medical Officer or Regional Technical Director should contact the Chief Medical Officer or Director, Emergency Disaster Management & Special Services (EDMSS).

II. The Chief Medical Officer (CMO) or Director, EDMSS or Designate will coordinate this response with the Jamaica Defence Force.

III. Where possible, the CMO or Director EDMSS or designate will coordinate and facilitate an emergency medical team to travel from the point of airlift dispatch to pick-up and accompany the patient to the destination tertiary care facility. This is to reduce the incidence of emergency medical teams being mobilized from patient pick-up point, travel by air to destination and having to return by ground transportation.

IV. Completed Referral Form A and all investigations should be part of the referral package.

V. All equipment and supplies for resuscitation must accompany patient.

VI. The family should be appropriately advised.

3.7.3 PROTOCOL FOR INTERNATIONAL PATIENT TRANSFER

Under specific circumstances the Ministry of Health may be required to coordinate international patient transfer. Should that be required, the following obtains:

I. The consultant, Senior Medical Officer or Regional Technical Director should consult the CMO or Director, EDMSS or designate.
II. The consultant, relatives or Director EDMSS (depending on circumstances) should contact the receiving international facility and lead physician.
III. The receiving international facility and lead physician must provide concurrence for patient transfer.
IV. Proof of possession of all documents necessary for travel must be demonstrated by patient/relatives. If required, the CMO or Director EDMSS or designate, through the Director International Cooperation in Health will seek to assist in obtaining a Visa (where required) for medical treatment abroad.
V. Patient, relatives or particular donor agency must demonstrate all financial guarantees.
VI. The CMO or Director EDMSS or designate, through the Director International Cooperation in Health, if required, will seek to coordinate the services of an air ambulance.

3.8 PROTOCOL FOR REFERRAL TO TYPE S HOSPITALS

Type S hospitals are unique, highly specialized tertiary care hospitals, which provide single specialist services at the national level of the health system. The services provided are: paediatric care (Bustamante Hospital for Children); gynaecology & obstetrics (Victoria Jubilee Hospital); psychiatric care (Bellevue Hospital); chest medicine and surgery (National Chest Hospital); oncology and palliative care (Hope Institute Hospital); and orthopaedic and spinal injury rehabilitation (Sir John Golding Rehabilitation Institute). The facilities are staffed with highly experienced consultants and specialists.

The general principles of patient referral, transfer and counter-referral between institutions apply, however institution-specific requirements exist. Protocols for referral to each of these facilities are outlined below.

3.8.1 REFERRAL PROTOCOL FOR BUSTAMANTE HOSPITAL FOR CHILDREN (BHC)

The Bustamante Hospital for Children caters for children under 12 years of age and accepts referrals for various subspecialty disciplines from private health care, primary and secondary care services. When a patient is being transferred to this facility, the relevant completed consent forms must be witnessed and signed to accompany the patient. This includes consent for investigations and treatment; consent for transfusion of blood products and for surgery if required; parents' names, address and contact numbers must also accompany patients.

In addition to the general principles of patient referral, transfer and counter-referral, children who are being followed up in particular specialist services at the BHC should be discharged to the nearest health care facility to continue care. This may be a primary or secondary care facility depending on the service required. Continuing specialist review can follow in conjunction with primary care team as required.

Referral for the adolescent patient should be to the relevant adolescent or adult health care facility (primary or secondary care), which is in closest proximity to where the adolescent normally resides. A detailed Summary letter must accompany the patient outlining treatment received, current medication being received and continued plan of therapy.

I. It is the responsibility of the Consultant in-charge or Senior Resident to complete a comprehensive summary for patient referral.
II. The Consultant in-charge/ Senior Resident should make contact with the relevant secondary or primary care service physician to discuss transfer and follow-up.
III. Parents and guardians should be an intimate part of the discussion and decision-making.
IV. ***Referral Form A*** and relevant investigations should be part of the referral package.

V. At the request and convenience of the parents / guardian, and after having written consent from the parent / guardian, the consultant or senior resident will provide discharge summary and refer patient to desired private physician who has the relevant and necessary competencies.

3.8.2 REFERRAL PROTOCOL FOR THE BELLEVUE HOSPITAL (BVH)

The Bellevue Hospital is a tertiary care psychiatric facility. It offers services to secondary care facilities that are unable to stabilize acutely ill patients at that level. A specialist psychiatric clinic is also operational at the facility. Historically, the BVH has received walk-in patients. However, it is preferable that patients in the community should first be assessed and or managed by the community psychiatrist or mental health officers, who may refer patients for admission and stabilization.

I. When possible, self-referred patients and those not acutely ill should generally be referred to and be managed at the Windward Road Health Centre, which is a primary care health centre in the Kingston Metropolitan Region, for specialist psychiatric services.
II. Where possible, prior to referral from the public health sector to the BVH, patients should be assessed by a psychiatrist or a Mental Health Officer. The Police may also bring in patients from court with or without referral.
III. Any Medical Officer of a Public or Private Facility may refer patients for Emergency Assessment / Care to the Emergency Room of the Hospital. Triage will be done at ER of Bellevue Hospital and necessary treatment will be offered based on the nature of Emergency. A letter of referral and or direct dialogue is preferred way of communication between that Medical Officer and the On-duty (Residents/Consultant) of the Bellevue Hospital. Public sector medical officers must complete ***Referral Form A***.
IV. Patients from nursing homes, shelters or those remanded in custody should be referred to the Emergency Room at BVH where they are evaluated and managed as per the hospital's policies and procedures. In the case of persons in custody, letter

of referral should be presented and the JCF/JDF are expected to provide security coverage.

V. Bellevue Hospital does not accept Direct Transfer from any overseas Hospitals, Forensic Psychiatric Facilities or Prisons. ALL deported mentally ill person who is referred to the BVH, will be triaged and seen at Emergency Room or Specialist Psychiatric Clinic.

VI. When efforts to stabilize the acutely ill patient at the secondary care level have been exhausted without resolve, transfer to the BVH should be considered.

VII. The psychiatrist should make contact with the consultant on call at BVH to obtain concurrence for transfer.

VIII. Under no circumstance should a patient be transferred to the BVH without consultation and concurrence or for social reasons.

IX. Transfers to BVH should preferably be between the hours of 8:00 am to 8:00pm.

X. Referral Form A and relevant investigations should be part of the referral package.

XI. Once any patient has been stabilized at BVH, a counter-referral should be made to the Community Mental Health Services or hospitals in the geographic location from where the patient originated. A copy of the discharge summary should also be sent to the Medical Officer (Health), primary or secondary care psychiatrist from where the referral originated.

Patients resident and other in-patients at the BVH may develop non-emergency and emergency medical, surgical, or gynaecological conditions. Where there is suspicion of such conditions, the residential and other in-patient should be referred to the specific specialty service at the Kingston Public Hospital (KPH), Victoria Jubilee Hospital (VJH) or other institution as guided by hospital policy and subspecialty need. Referral Form A must be completed.

I. Under the authority of the consultant at BVH contact should be made with the relevant Medical Officer/Specialist /Specialty Clinic regarding referral and counter-referral and transfer.

II. Based on the nature of the condition, instructions may be given

for immediate transfer of the patient to a predetermined ward or to the outpatient clinic, where the patient can be further assessed.

III. Referral Form A and relevant investigations as well as a summary of the prevailing conditions should form part of the referral package.

IV. Where the patient is accepted for admission to the KPH or VJH, the KPH or VJH service team leader should inform the psychiatrist attached to the institution, to ensure continuity of psychiatric care.

V. As soon as the medical condition has resolved, a discharge medical and psychiatric summary and a counter-referral/transfer to BVH or discharge to Primary Care and Community Mental Health Services as guided by the in-house psychiatrist using Part II of Referral Form A. A discharge medical and psychiatric summary must always be sent to BVH for residential and in-patients of BVH and a copy attached to Referral Form A.

VI. Outpatients of BVH discharged from any Public Hospital should always be referred to Community Mental Health Services nearest to their place of residence.

VII. If the patient is sufficiently stable and there is evidence of community / home support, under the coverage of the psychiatrist, that patient may be referred directly to Community Mental Health Services using Referral Form A. A copy of the discharge summary must also be included.

3.8.3 REFERRAL PROTOCOL FOR THE HOPE INSTITUTE HOSPITAL

The Hope Institute Hospital offers a full range of specialist oncology services, which includes in-patient and outpatient care, chemotherapy administration, palliative care, pain management and advice on radiation oncology. There is a very close relationship between KPH, National Chest Hospital (NCH) and Hope Institute Hospital, in that outpatient clinics are conducted in these institutions by the medical staff of the Hope Institute Hospital. Patients undergoing radiation

therapy at KPH are admitted to, and jointly managed by teams based at Hope and at the Radiotherapy Department at KPH.
There is no drop-in service at Hope Institute; care can only be accessed through referrals from the public or private sector.

I. Patients at the NCH or KPH should be referred using ***Referral Form B*** only. These patients will be seen with their full dockets at the respective facilities.
II. Patients from other facilities must be referred using Referral Form A or a letter head from a private facility or from the University Hospital.
III. The Consultant Oncologist at Hope Institute should be called when a referral outside of KPH and NCH is being considered, so that an appropriate date and time may be coordinated.
IV. The referring consultant should ensure that all relevant investigations including scans and histopathology reports are included in the referral package.
V. A counter-referral is completed in the dockets of patients at the KPH and NCH, while for all other facilities Part II of ***Referral Form A*** is completed.

3.8.4 REFERRAL PROTOCOL FOR NATIONAL CHEST HOSPITAL

The National Chest Hospital specializes in pulmonary medicine and surgery. At NCH a range of pulmonary services are offered, as patients may present for care of acute or exacerbated respiratory conditions or through a referral. The general principles of referral, transfer and counter-referral apply except in the case of referrals to oncology conducted by Hope Institute at NCH. In this case ***Referral Form B*** attached to the patient's docket is used.

3.8.5 REFERRAL PROTOCOL FOR SIR JOHN GOLDING REHABILITATION CENTRE

The Sir John Golding Rehabilitation Centre is a 70-bed facility dedicated to the treatment and rehabilitation of patients with spinal cord injuries mostly due to accidents, stroke, congenital limb weaknesses and

deformities. Additionally, lower limb prostheses are fabricated and fitted at the centre, enabling ambulation. There is no drop-in service at the Sir John Golding Rehabilitation Centre, and care can **only be accessed** through referrals from the public or private sector.

I. To facilitate admission, the referring physician should call the centre to discuss the case and make an appointment.
II. Patients must be referred using ***Referral Form A*** or a letter head from a private facility or the University Hospital.
III. The referring physician should ensure that all relevant investigations including scans are included in the referral package.
IV. A counter-referral is completed on Part II of ***Referral Form A*** and returned to the originating consultant / facility.
V. When patient function has been optimized the patient is counter-referred to the facility of origin or primary health care facility in closest geographic proximity to where the patient normally lives. A discharge summary with instructions on care is submitted to the referring physician who accepts further responsibility for continued care.

3.8.6 REFERRAL PROTOCOL FOR VICTORIA JUBILEE HOSPITAL (VJH)

The Victoria Jubilee Hospital is the only specialized maternal hospital, which has existed since 1887. The VJH offers services in family planning, sickle cell screening, antenatal and post-natal services as well as hearing screening. Patients, especially high-risk obstetrics, are referred and accepted from private and public facilities across the country. Transfers into the VJH require adherence to the following:

I. The referring consultant/Doctor in Charge **MUST** consult with the Consultant on Duty prior to any transfer.
II. The reason for the referral must be clearly documented and the patient must be accepted by the consultant/senior resident prior to the patient's arrival.
III. Accompanying the patient must be a clinical summary and the

result of all investigations done previously.

IV. For obstetrics patient (>20 weeks gestation), the blue Maternal Record booklet **(NOT the Referral Form A)** should be used when being referred to the hospital. The form must be completed and accompany the patient.

V. For patients less than 20 weeks gestation, Referral Form A **MUST** be completed.

The counter-referral process from VJH to the facility of origin requires that:

I. A clinical summary signed by the consultant or senior resident must accompany patient.

II. A follow up treatment plan should be in place.

III. A statement be provided indicating the conditions under which immediate re-referral would be necessary.

IV. Counter-referral form (Referral Form A) is completed if patient is gynaecological or postnatal.

V. Blue Maternal Record booklet is completed for the obstetric patient.

The VJH is situated in the same geographical location as KPH (a type A hospital) and enjoys a very close relationship, which includes sharing of various resources including infrastructure and staff. Patients at VJH sometimes develop various medical or surgical complications including emergencies requiring non-obstetric/gynaecology intervention. Similarly, female patients at the KPH may also require expertise from obstetrics and gynaecology.

To facilitate referral of patients between the two facilities, the following must be conducted or provided:

I. Prior discussions with the receiving consultant

II. Clinical summary (which must accompany the patient)

III. A copy of investigations done (which must accompany patient)

IV. Completed ***Referral Form B***.

4.
MONITORING AND EVALUATION

Monitoring and evaluation (M&E) is critical in assessment of the quality of patient care and patient safety and is an essential component of system improvement.

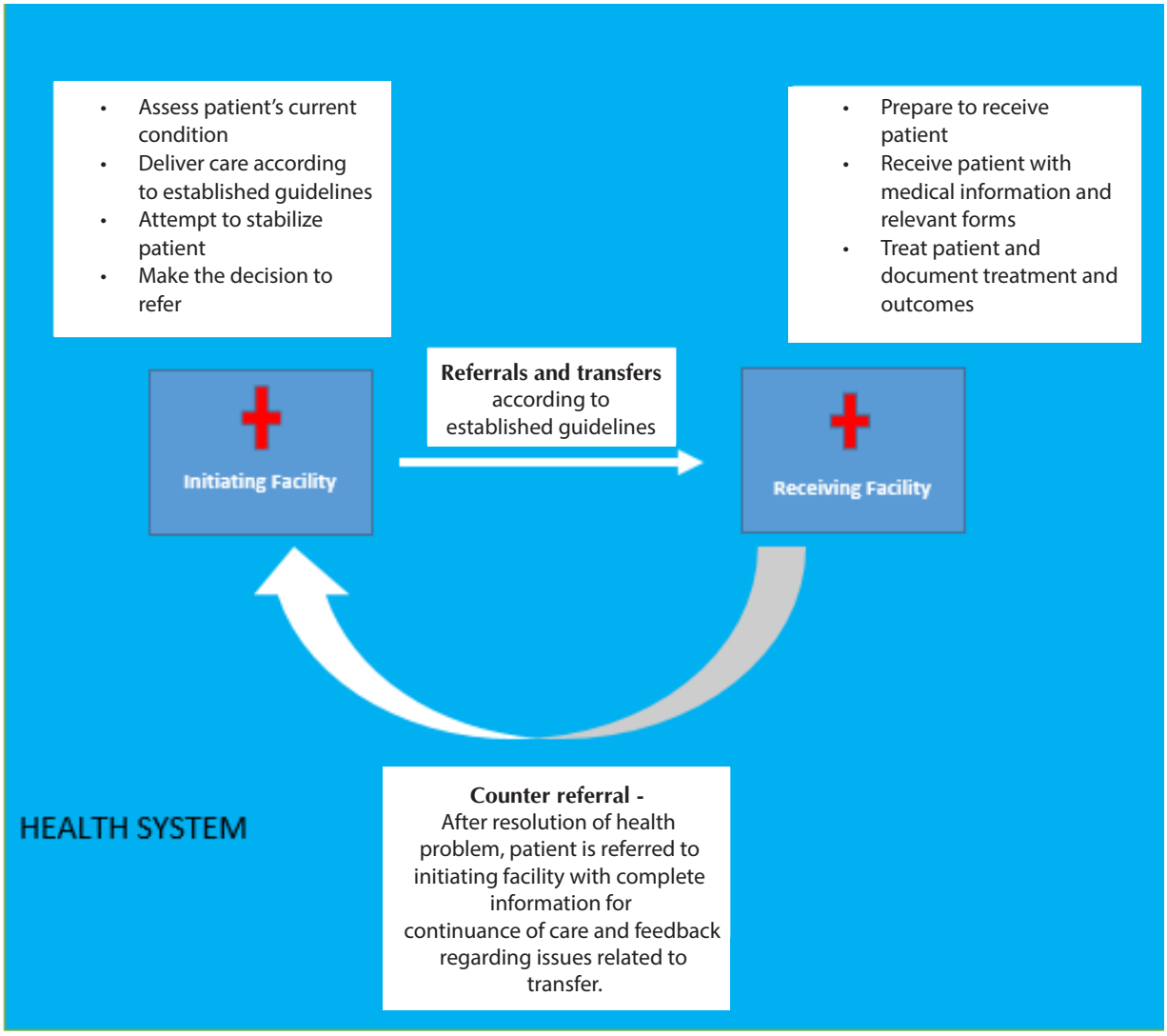
Within the M&E framework the following should be assessed and reported on a quarterly basis:

- Referral rate = The number of referrals per 100 new patients
- Acceptance
- Compliance of referrals
- Patient care during transfer
- Patient hand over
- Counter-referral (feedback) within 30 days of referral/transfer
- Validity of referral

The Health Services Support and Monitoring Unit of the Ministry will periodically monitor and evaluate the performance of the National Referral System.

5.
APPENDIX

APPENDIX 1: NATIONAL REFERRAL SYSTEM



APPENDIX 2: GLOSSARY OF KEY TERMS

TERM	MEANING
Counter-referral	The process of re-directing the referred patient to the originating healthcare facility once the reason for referral has been resolved. This two-way process ensures efficiency in the continuum of care.
Handing over	Delivery of patient and documents to relevant section of receiving institution/facility.
Initiating/Referring facility	Facility from which a patient is referred.
Receiving facility	Facility accepting referral.
Referral	Process through which health care providers, who do not possess the specific expertise or access to specific resources, or both, refer patients to other providers who are specially trained or better equipped. Referrals are conducted for: Obtaining expert clinical opinion/advice; Access to diagnostic, care and treatment services beyond the referring facility's capability (expertise and health technologies); Admission for more specialized management of a given clinical condition.
Referral, External	Referral between different health institutions within the same Region or from one Region to another.
Referral, Internal	Referral between different specialist services of the same institution.
Referral, Inter-RHA	External or between Regions.
Referral, Intra-RHA	Between levels and facilities within a Region.
Self-refer	To seek access to specialist, secondary or tertiary facilities/care without being referred by a health professional. This is not permissible in the majority of instances.
Transfer	The action of placing responsibility for the care of a patient from one physician/facility to another.
Transport	To move patient from one facility to the next, during the referral process.

APPENDIX 3: GEOGRAPHIC LOCATION OF PRIMARY HEALTH CARE FACILITIES

A: PRIMARY CARE FACILITIES PER CLASSIFICATION

OLD CLASSIFICATION of PRIMARY CARE FACILITIES		RECLASSIFIED PRIMARY CARE		
HEALTH CENTRE	NUMBER	HEALTH CENTRE	NUMBER	POPULATION
TYPE 1	149	Community Health Centre	159	10,000– 30,000
TYPE II	92			
TYPE III	65	District Health Centre	65	30,000– 60,000
TYPE IV	7	Parish Health Centre*	11	30,000– 60,000
TYPE V	4	Comprehensive Health Centre	7	> 60,000
Community Hospital	3	Community Hospital	2	
Satellite Health Centre	23	Satellite Health Centre	70	< 15,000
Dental Clinic	9	Dental Clinic	8	
Specialist Clinic	2	Specialist Clinic	2	
Rural Maternity Centre	2	Rural Maternity Centre	2	
TOTAL	356		327	
* Parish Health Centre will be based at Parish township; if possible, in close proximity to Parish Hospital				

B: PRIMARY CARE FACILITIES DISAGGREGATED PER REGION, PARISH AND CLASSIFICATION

HEALTH DISTRICT/ ZONE	OLD NOMEN CLATURE	HEALTH CENTRE NAME	RECLASSIFICATION	REMARKS
SOUTH EAST REGIONAL HEALTH AUTHORITY				
ST CATHERINE				
PORTMORE/1	III	GREATER PORTMORE	COMPREHENSIVE	Total 36 Facilities Previous Classification • **Type IV × 1** • **Type III × 5** • **Type II × 12** • **Type I × 8** • **Satellite × 9** • **Dental × 1**
	II	CHRISTIAN PEN	DISTRICT	
	II	WATERFORD	DISTRICT	
	DENTAL	BRIDGEPORT D/C	DENTAL/SATELLITE	
SPANISH TOWN/2	IV	ST. JAGO PARK	COMPREHENSIVE	
	III	SYDENHAM	DISTRICT	
	SATELLITE	ELTHAM	DISTRICT	
	I	CENTRAL VILLAGE	COMMUNITY	

HEALTH DISTRICT/ ZONE	OLD NOMEN-CLATURE	HEALTH CENTRE NAME	RECLASSIFICATION	REMARKS
	II	SLIGOVILLE	COMMUNITY	
	II	CUMBERLAND RD.	COMMUNITY	
	II	KITSON TOWN	DISTRICT	
OLD HARBOUR/3	II	POINT HILL	COMMUNITY	
	III	OLD HARBOUR	PARISH	
	I	LLUIDASVALE	COMMUNITY	
	SATELLITE	SPRING VILLAGE	SATELLITE	
	SATELLITE	BELLAS GATE	SATELLITE	
	SATELLITE	BOIS CONTENT	SATELLITE	
	SATELLITE	MENDEZ	SATELLITE	
	II	OLD HARBOUR BAY	COMMUNITY	
	SATELLITE	CHURCH PEN	SATELLITE	
	I	BARTONS	SATELLITE	
	II	CONNORS	COMMUNITY	
	I	WATERMOUNT	SATELLITE	
LINSTEAD/4	III	LINSTEAD	PARISH	
	II	BOGWALK	DISTRICT	
	II	EWARTON	COMMUNITY	
	II	GUYS HILL	COMMUNITY	
	III	RIVERSDALE	COMMUNITY	
	II	GLENGOFFE	SATELLITE	
	SATELLITE	CHEESEFIELD	SATELLITE	
	SATELLITE	ORANGEFIELD	SATELLITE	
	SATELLITE	GIBLATORE	SATELLITE	
	I	TREADWAYS	SATELLITE	
	I	TROJA	SATELLITE	
	I	REDWOOD	SATELLITE	
	I	HARKER'S HALL	COMMUNITY	
ST. THOMAS				
EASTERN /1	II	BATH	DISTRICT	Total 17 Facilities Previous Classification • **Type IV × 1** • **Type III × 3** • **Type II × 4** • **Type I ×9** New Classification • **Parish × 1** • **District × 5** • **Community × 4** • **Satellite × 7**
	III	ISAAC BARRANT *	DISTRICT	
	I	ROWLANDSFIELD	SATELLITE	
SOUTHERN /2	IV	MORANT BAY	PARISH	
	II	PORT MORANT	DISTRICT	
	I	WHITE HORSES	COMMUNITY	
	I	ARCADIA	SATELLITE	
NORTHWESTERN /3	III	SEAFORTH	DISTRICT	
	II	TRINITYVILLE	COMMUNITY	
	I	CEDAR VALLEY	COMMUNITY	
	I	DANVERS PEN	SATELLITE	
	I	HAGLEY GAP	SATELLITE	
	I	WHITEHALL	SATELLITE	
	I	FONTHILL	SATELLITE	
SOUTHWESTERN (4)	III	YALLAHS	DISTRICT	
	II	LLANDEWEY	COMMUNITY	
	I	LLOYDS	SATELLITE	

New Classification
- **Comprehensive × 2**
- **Parish × 2**
- **District × 6**
- **Community × 11**
- **Satellite × 14**
- **Dental × 1**

KINGSTON & ST. ANDREW

HEALTH DISTRICT/ ZONE	OLD NOMEN CLATURE	HEALTH CENTRE NAME	RECLASSIFICATION	REMARKS
ZONE 1	V	WINDWARD ROAD	COMPREHENSIVE	Total 48 Facilities **Previous Classification** • **Type V × 3** • **Type III × 16** • **Type II × 9** • **Type I ×10** • **Dental × 6** • **Specialist × 1** • **Satellite × 3** New Classification • **Comprehensive × 4** • **District × 17** • **Community × 12** • **Dental × 6** • **Specialist × 1** • **Satellite × 7** Additionally the following facilities have specific characteristics: • **Windward Rd offers specialist mental health services.** • **Vouch offers curative services operated by an NGO** • **Lenworth Jacobs offers specialist family planning operated by an NGO** • **Slipe Pen Rd offers specialist services in STIs** • **Glenn Vincent has a special focus paediatric mental health** • **Operation Friendship is an NGO operated facility** • **Maxfield Park offers specialist services in dental and mental health** • **Majesty Gardens is operated by an NGO**
	III	NORMAN GARDENS	DISTRICT	
	III	ROLLINGTON TOWN	DISTRICT	
	III	HARBOUR VIEW	DISTRICT	
	II	BULL BAY	COMMUNITY	
	II	NANNYVILLE	COMMUNITY	
	II	PORT ROYAL	COMMUNITY	
	II	VOUCH	DISTRICT	
	SPECIALIST	LENWORTH JACOBS FPC	FAMILY PLANNING/ SPECIALIST	
	DENTAL	EAST QUEEN ST.	DENTAL/SATELLITE	
	DENTAL	ALPHA	DENTAL/SATELLITE	
ZONE 2	V	SLIPE PEN ROAD	COMPREHENSIVE	
	III	GLEN VINCENT	DISTRICT	
	II	OPERATION FRIENDSHIP	COMMUNITY	
	III	DENHAM TOWN	DISTRICT	
	DENTAL	HOLYCHILDHOOD D/C	DENTAL/SATELLITE	
	SATELLITE	VJH	SATELLITE	
ZONE 3	V	MAXFIELD PARK	COMPREHENSIVE	
	III	HAGLEY PARK	DISTRICT	
	III	OLYMPIC GARDENS	DISTRICT	
	III	SEAVIEW GARDENS	DISTRICT	
	I	MAJESTY GNS.	SATELLITE	
	DENTAL	MYRTH COORE	DENTAL/SATELLITE	
ZONE 4	III	DUHANEY PARK	DISTRICT	
	III	SUNRISE	DISTRICT	
	III	RED HILLS	DISTRICT	
	III	DREWSLAND	COMMUNITY	
	I	ROCKHALL	SATELLITE	
	I	PADMORE	SATELLITE	
ZONE 5	III	STONY HILL	DISTRICT	
	II	LAWRENCE TAVERN	DISTRICT	
	III	EDNA MANLEY	DISTRICT	
	I	ESSEX HALL	COMMUNITY	
	I	MOUNT CHARLES	COMMUNITY	
	I	PARKS ROAD	COMMUNITY	
	I	KING WESTON	COMMUNITY	
	I	GOLDEN SPRING	COMMUNITY	
	SATELLITE	BRANDON HILL	SATELLITE	
ZONE 6	III	GORDON TOWN	DISTRICT	
	III	S&PM–UHWI	DISTRICT	
	II	MAVIS BANK	COMMUNITY	
	II	ST. MARGARET'S	SATELLITE	
	II	DALLAS	COMMUNITY	
	I	HALL'S DELIGHT	SATELLITE	
	I	CONTENT GAP	SATELLITE	
	SATELLITE	MOUNT PLEASANT	SATELLITE	
	DENTAL	JAMAICA COLLEGE	DENTAL/ SATELLITE	
	DENTAL	NATIONAL CHEST HOSPITAL - D/C	DENTAL/ SATELLITE	

HEALTH DISTRICT/ ZONE	OLD NOMEN CLATURE	HEALTH CENTRE NAME	RECLASSIFICATION	REMARKS
WESTERN REGIONAL HEALTH AUTHORITY				
TRELAWNY				
FALMOUTH	IV	FALMOUTH	PARISH	TOTAL 19 FACILITIES **Previous Classification** • Type IV × 1 • Type III × 2 • TypeII × 6 • Type I × 9 • RMC × 1 **New Classification** • **Parish × 1** • **District × 6** • **Community × 4** • **RMC × 1** • **Satellite × 7**
	II	WAKEFIELD	DISTRICT	
	I	DEESIDE	SATELLITE	
	I	BOUNTY HALL	COMMUNITY	
	I	SHERWOOD CONTENT	SATELLITE	
	I	BUNKERS HILL	SATELLITE	
ALBERT TOWN	III	ALBERT TOWN	DISTRICT	
	II	WAITA-BIT	COMMUNITY	
	II	WARSOP	COMMUNITY	
	II	ULSTER SPRING	DISTRICT	
	I	TROY	SATELLITE	
	I	LOWE RIVER	COMMUNITY	
	I	ROCK SPRING	SATELLITE	
DUNCANS	III	DUNCANS	DISTRICT	
	II	DUANVALE	DISTRICT	
	II	JACKSON TOWN	DISTRICT	
	I	RIO BUENO	SATELLITE	
	I	STEWART TOWN	SATELLITE	
WESTMORELAND				
SAVANNA-LA-MAR	III	SAVANNA-LA-MAR	PARISH	TOTAL 19 FACILITIES **Previous Classification** • Type III × 5 • Type II × 5 • Type I × 9 **New Classification** • **Parish × 1** • **District × 5** • **Community × 8** • **Satellite × 5**
	II	PETERSFIELD	COMMUNITY	
	I	WILLIAMSFIELD	COMMUNITY	
GRANGE HILL	III	GRANGE HILL	DISTRICT	
	I	BAULK	COMMUNITY	
	I	GEORGE'S PLAIN	COMMUNITY	
NEGRIL	III	NEGRIL	DISTRICT	
	II	LITTLE LONDON	COMMUNITY	
	I	DELVELAND	COMMUNITY	
WHITEHOUSE	II	WHITEHOUSE	DISTRICT	
	I	BLUEFIELDS	COMMUNITY	
	I	BEESTON SPRING	SATELLITE	
	I	NEW WORKS	SATELLITE	
DARLISTON & BETHEL TOWN	III	DARLISTON *	DISTRICT	
	III	BETHEL TOWN	DISTRICT	
	II	LAMBS RIVER	COMMUNITY	
	I	CORNWALL MOUNTAIN	SATELLITE	
	I	ST. LEONARDS	SATELLITE	
	I	BERKSHIRE	SATELLITE	
ST JAMES				
MONTEGO BAY	V	CREEK STREET/MO-BAY	COMPREHENSIVE	TOTAL 20 FACILITIES **Previous Classification** • Type V × 1 • Type III × 3 • Type II × 8
	I	GLENDEVON	COMMUNITY	
	I	FLANKERS	COMMUNITY	
	II	MOUNT SALEM	COMMUNITY	
	II	SALT SPRING	COMMUNITY	

HEALTH DISTRICT/ ZONE	OLD NOMEN CLATURE	HEALTH CENTRE NAME	RECLASSIFICATION	REMARKS
	SATELLITE	LILLIPUT	COMMUNITY	• Type I × 7 • Satellite × 1 **New Classification** • **Comprehensive × 1** • **District × 4** • **Community × 14** • **Satellite × 1**
	I	GREEN POND	DISTRICT	
	I	BARRETT TOWN	COMMUNITY	
CATHERINE HALL	II	GRANVILLE	COMMUNITY	
	II	ADELPHI	COMMUNITY	
	I	SOMERTON	COMMUNITY	
	III	CATHERINE HALL	DISTRICT	
	I	LOTTERY	SATELLITE	
CAMBRIDGE	III	CAMBRIDGE	DISTRICT	
	II	ROEHAMPTON	COMMUNITY	
	II	CATADUPA	COMMUNITY	
	II	MOUNT CAREY	COMMUNITY	
MAROON TOWN	III	MAROON TOWN	DISTRICT	
	I	GARLANDS	COMMUNITY	
	II	SPRINGFIELD	COMMUNITY	
HANOVER				
LUCEA	IV	LUCEA	PARISH	TOTAL 19 FACILITIES **Previous Classification** • Type IV × 1 • Type III × 2 • Type II × 8 • Type I × 8 **New Classification** • **Parish × 1** • **District × 2** • **Community × 13** • **Satellite × 3**
	II	DIAS	COMMINITY	
	I	ASKENISH	COMMUNITY	
	II	MARYLAND	COMMUNITY	
	II	CASCADE	COMMUNITY	
	I	KINGSVILLE	COMMUNITY	
GREEN ISLAND	III	GREEN ISLAND	DISTRICT	
	II	CAVE VALLEY	COMMUNITY	
	II	GRANGE / KENDAL	COMMUNITY	
	I	LOG WOOD	COMMUNITY	
HOPEWELL	III	HOPEWELL	DISTRICT	
	II	RAMBLE	COMMUNITY	
	II	SANDY BAY	COMMUNITY	
	I	MOUNTPELIER	SATELLITE	
	II	CHESTER CASTLE	COMMUNITY	
	I	MT. PETO	SATELLITE	
	I	COPSE	COMMUNITY	
NORTH EAST REGIONAL HEALTH AUTHORITY				
PORTLAND				
PORT ANTONIO	IV	PORT ANTONIO	PARISH	TOTAL 19 FACILITIES **Previous Classification** • Type IV × 1 • Type III × 1 • Type II × 4 • Type I × 10 • Community Hospital × 1 • Dental × 2 **New Classification** • **Parish × 1** • **District × 1**
	II	FELLOWSHIP	COMMUNITY	
	I	MOORE TOWN	COMMUNITY	
	I	NONSUCH	SATELLITE	
	II	MOUNT PLEASANT	COMMUNITY	
	I	ST. MARGARETS BAY	SATELLITE	
BUFF BAY	COMMUNITY HOSPITAL	BUFF BAY	COMMUNITY HOSPITAL	
	I	SWIFT RIVER	COMMUNITY	
	II	HOPE BAY	COMMUNITY	
	I	BANGOR RIDGE	COMMUNITY	

HEALTH DISTRICT/ ZONE	OLD NOMEN CLATURE	HEALTH CENTRE NAME	RECLASSIFICATION	REMARKS
	I	SPRING HILL	COMMUNITY	• **Community × 10** • Community Hospital × 1 • **Satellite × 4** • Dental × 2
	I	FRUITFUL VALE	COMMUNITY	
	I	CASCADE	SATELLITE	
	I	CHEPSTOWE	SATELLITE	
MANCHIONEAL	III	MANCHIONEAL	DISTRICT	
	I	FAIRY HILL	COMMUNITY	
	II	FAIR PROSPECT	COMMUNITY	
	DENTAL	KATUS BLAKEY	DENTAL/SATELLITE	
	DENTAL	PORT ANTONIO PRIMARY D/C	DENTAL/SATELLITE	
ST. MARY				
PORT MARIA	III	PORT MARIA	PARISH	TOTAL 31 FACILITIES **Previous Classification** • Type III × 4 • Type II × 8 • Type I × 19 • Satellite × 2 **New Classification** • **Parish × 1** • **District × 3** • **Community × 25** • **Satellite × 2**
	II	ISLINGTON	COMMUNITY	
	II	ORACABESSA	COMMUNITY	
	I	OXFORD	COMMUNITY	
	I	MASON HALL	COMMUNITY	
	I	ALBANY	COMMUNITY	
	I	HEYWOOD HALL	COMMUNITY	
	I	ALBION MOUNTAIN	COMMUNITY	
HIGHGATE	III	HIGHGATE	DISTRICT	
	I	CLONMEL	COMMUNITY	
	I	BRAINERD	COMMUNITY	
	II	BELFIELD	COMMUNITY	
	II	WINDSOR CASTLE	COMMUNITY	
	I	BONNY GATE	COMMUNITY	
	I	FLINT RIVER	COMMUNITY	
	I	HAMPSTEAD	COMMUNITY	
GAYLE	III	GAYLE	DISTRICT	
	I	HUNTS TOWN	COMMUNITY	
	I	LABRYNTH	COMMUNITY	
	I	FELLOWSHIP HALL	COMMUNITY	
	II	WOOD PARK	COMMUNITY	
	II	RETREAT	COMMUNITY	
ANNOTTO BAY	III	ANNOTTO BAY	DISTRICT	
	II	ENFIELD	COMMUNITY	
	I	ROCK RIVER	COMMUNITY	
	II	CASTLETON	COMMUNITY	
	I	ROBINS BAY	COMMUNITY	
	I	LONG ROAD	COMMUNITY	
	I	CLARKE CASTLE	COMMUNITY	
	SAT.	CAMBERWELL	SATELLITE	
	SAT.	SCOTT'S HALL	SATELLITE	
ST. ANN				
ST. ANN'S BAY	IV	ST. ANN'S BAY	PARISH	TOTAL 29 FACILITIES **Previous Classification** • Type IV × 1 • Type III × 3 • Type II × 7
	I	STEER TOWN	COMMUNITY	
	I	LIME HALL	COMMUNITY	
	II	RUNAWAY BAY	COMMUNITY	
	SATELLITE	QUEENHYTHE	SATELLITE	

HEALTH DISTRICT/ ZONE	OLD NOMEN CLATURE	HEALTH CENTRE NAME	RECLASSIFICATION	REMARKS
	SPECIALIST	BETH JACOBS FPC.	FAMILY PLANNING/ SATELLITE	• Type I × 13 • **Satellite × 5** • **Specialist × 1** • Community Hospital × 1 **New Classification** • **Parish × 1** • **District × 3** • **Community × 19** • **Satellite × 4** • Community Hospital × 1 • Specialist– (Beth Jacob – NGO) × 1
OCHO RIOS	III	OCHO RIOS	DISTRICT	
	II	EXCHANGE	COMMUNITY	
	I	WALKERS WOOD	COMMUNITY	
	SATELLITE	BEECHER TOWN	SATELLITE	
CLAREMONT	III	CLAREMONT *	DISTRICT	
	II	BENSONTON	COMMUNITY	
	II	MONEAQUE	COMMUNITY	
	I	BLACKSTONEDGE	COMMUNITY	
	I	Mc NIE	COMMUNITY	
BROWN'S TOWN	III	BROWN'S TOWN	DISTRICT	
	II	BAMBOO	COMMUNITY	
	I	STURGE TOWN	COMMUNITY	
	II	WATT TOWN	COMMUNITY	
	I	GIBRALTAR	COMMUNITY	
	SATELLITE	MADRAS	COMMUNITY	
ALEXANDRIA	COMMUNITY HOSPTIAL	ALEXANDRIA	COMMUNITY HOSPITAL	
	I	BOROBRIDGE	COMMUNITY	
	II	STEPNEY	COMMUNITY	
	I	BOHEMIA	COMMUNITY	
	I	CLARKSONVILLE	COMMUNITY	
	I	MUIRHOUSE	COMMUNITY	
	SATELLITE	PRICKLE POLE	SATELLITE	
	SATELLITE	HIGGINS LAND	SATELLITE	
SOUTHERN REGIONAL HEALTH AUTHORITY				
CLARENDON				
SPALDING	III	SPALDING	COMMUNITY	TOTAL 30 FACILITIES **Previous Classification** • Type III × 9 • Type II × 9 • Type I × 11 • Community Hospital × 1 **New Classification** • **Parish × 1** • **District × 4** • **Community × 17** • **Satellite × 7** • Community Hospital × 1
	I	AENON TOWN	COMMUNITY	
	I	CUMBERLAND	SATELLITE	
	I	MORAVIA	SATELLITE	
FRANKFIELD	III	FRANKFIELD	DISTRICT	
	I	JAMES HILL	COMMUNITY	
	I	CROOKED RIVER	COMMUNITY	
THOMPSON TOWN	III	THOMPSON TOWN	COMMUNITY	
	II	MOCHO	DISTRICT	
	I	DARLOW	SATELLITE	
KELLITS	III	KELLITS	DISTRICT	
	III	CROFTS HILL	COMMUNITY	
	II	BRANDON HILL	COMMUNITY	
	I	RECKFORD	SATELLITE	
MAY PEN	III	BRYANTS CRESCENT	DISTRICT	
	I	SANDY BAY	COMMUNITY	
	I	HALSE HALL	COMMUNITY	
MAY PEN WEST	III	MAY PEN	PARISH	
	II	TOLL GATE	COMMUNITY	

HEALTH DISTRICT/ ZONE	OLD NOMEN CLATURE	HEALTH CENTRE NAME	RECLASSIFICATION	REMARKS
	II	YORK TOWN	COMMUNITY	
RACE COURSE	III	RACE COURSE	COMMUNITY	
	II	MILK RIVER	COMMUNITY	
CHAPELTON	COMMUNITY HOSPITAL	CHAPELTON	COMMUNITY HOSPITAL	
	II	ROCK RIVER	COMMUNITY	
	I	PENNANTS	COMMUNITY	
LIONEL TOWN	III	LIONEL TOWN	COMMUNITY	
	1	ROCKY POINT	SATELLITE	
	II	RAYMONDS	COMMUNITY	
	I	MITCHELL TOWN	SATELLITE	
	I	PORTLAND COTTAGE	SATELLITE	
MANCHESTER				
MANDEVILLE	III	MANDEVILLE	COMPREHENSIVE	TOTAL 22 FACILITIES **Previous Classification** • Type III × 6 • Type II × 5 • Type I × 8 • **Satellite × 3** **New Classification** • **Parish × 1** • **District × 5** • **Community × 8** • **Satellite × 8**
	II	LINCOLN	COMMUNITY	
	1	ROYAL FLAT	COMMUNITY	
PORUS	III	PORUS	DISTRICT	
	II	BELLEFIELD	COMMUNITY	
	I	BOMBAY	COMMUNITY	
	I	HARMONS	SATELLITE	
	SATELLITE	BANANA GROUND	SATELLITE	
	SAT.	BROADLEAF	SATELLITE	
CHRISTIANA	III	CHRISTIANA	DISTRICT	
	SATELLITE	COLEYVILLE	SATELLITE	
	I	WALDERSTON	SATELLITE	
	I	CRAIG HILL	COMMUNITY	
MILE GULLY	III	MILE GULLY	DISTRICT	
	II	HARRY WATCH	COMMUNITY	
	I	MAIDSTONE	SATELLITE	
CROSS KEYS	III	CROSS KEYS	DISTRICT	
	II	DOWNS	COMMUNITY	
NEW PORT	III	NEW PORT	DISTRICT	
	II	PRATVILLE	COMMUNITY	
	I	OLD ENGLAND	SATELLITE	
	I	WINDSOR FORREST	SATELLITE	
ST. ELIZABETH				
BALACLAVA	III	BALACLAVA	DISTRICT	TOTAL 20 FACILITIES **Previous Classification** • Type IV × 1 • Type III × 6 • Type II × 6 • Type I × 6 • **Rural Maternity Centre× 1** **New Classification** • **Parish × 1** • **District × 3** • **Community × 15** • **Rural Maternity**
	II	ABERDEEN	COMMUNITY	
	II	APPLETON ESTATE	COMMUNITY	
BLACK RIVER	IV	BLACK RIVER	DISTRICT	
	I	GINGER HILL	COMMUNITY	
	I	SPRINGFIELD	COMMUNITY	
	I	NEW MARKET	COMMUNIT	
JUNCTION	III	JUNCTION	DISTRICT	
	II	MALVERN	COMMUNITY	
	II	PORTSEA	COMMUNITY	
MAGGOTTY	III	MAGGOTTY	COMMUNITY	
	I	BETHSALEM	COMMUNITY	

HEALTH DISTRICT/ ZONE	OLD NOMEN CLATURE	HEALTH CENTRE NAME	RECLASSIFICATION	REMARKS
	II	ELDERSLIE	COMMUNITY	**Centre × 1** Elderslie also has a Birthing Unit
SANTA CRUZ	III	SANTA CRUZ	PARISH *	
	II	PEPPER	COMMUNITY	
	1	MYERSVILLE	COMMUNITY	
	III	LACOVIA	COMMUNITY	
SOUTHFIELD	III	SOUTHFIELD	COMMUNITY	
	RMC	NEWEL (RMC)	RMC	
	I	BELLEVUE	COMMUNITY	

* Primary Care Facilities designated Centres of Excellence in Phase 1.	
Isaac Barrant	Claremont
Santa Cruz	Darliston

APPENDIX 4: PUBLIC HOSPITALS

REGION /PARISH		HOSPITAL	TYPE	BED CAPACITY	SERVICE
SOUTH EAST REGIONAL HEALTH AUTHORITY	Kingston	Kingston Public	A	500	Highly specialized multidisciplinary, subspecialty and support services
	Kingston	Victoria Jubilee	S	304	Obstetrics &Gynaecology
	Kingston	Bellevue	S	800	Psychiatry
	Kingston	Bustamante Hospital for Children	S	283	Paediatrics
	St. Andrew	University Hospital of the West Indies	A	579	Highly specialized multidisciplinary, subspecialty and support services
	St. Andrew	National Chest	S	90	Pulmonary medicine and surgery
	St. Andrew	Sir John Golding Rehabilitation Centre	S	70	Orthopaedic/Spinal injury rehabilitation
	St. Andrew	Hope Institute	S	40	Oncology and Palliative Care
	St. Catherine	Spanish Town	B+	425	Specialist services general surgery, internal medicine, OBGYN &Paediatrics. Full array of laboratory, x-ray, nutrition and physiotherapy services.
	St. Catherine	Linstead	C	52	Uncomplicated inpatient and outpatient medicine, surgery, paediatrics & OBGYN. Basic lab &X-ray
	St. Thomas	Princess Margaret	C	129	Specialist services general surgery, internal medicine, OBGYN & paediatrics. Basic lab & x-ray
NORTH EAST	Portland	Port Antonio	C+	95	Specialist services in general surgery, internal medicine, OBGYN & paediatrics. Basic lab & x-ray
	St. Mary	Port Maria	C	60	Uncomplicated inpatient and outpatient general medicine& OBGYN. Basic lab &x-ray

REGION /PARISH		HOSPITAL	TYPE	BED CAPACITY	SERVICE
	St. Mary	Annotto Bay	C+	117	Specialist services general surgery, internal medicine, OBGYN & paediatrics. Basic lab & x-ray
	St. Ann	St. Ann's Bay	B+	271	Inpatients and outpatient specialist services in: surgery, Internal medicine, orthopaedics, psychiatry, OBGYN &paediatrics. Full array of laboratory, x-ray, nutrition and physiotherapy
WESTERN REGIONAL HEALTH AUTHORITY	Trelawny	Falmouth	C+	111	Uncomplicated inpatient and outpatient general medicine, paediatrics, general surgery & OBGYN. Basic lab & x-ray
	St. James	Cornwall Regional	A	417	Highly specialized multidisciplinary, subspecialty and support services
	Hanover	Noel Holmes	C	38	Uncomplicated and minimal inpatient and outpatient general medicine, paediatrics & OBGYN. Basic lab & x-ray
	Westmoreland	Savanna-La-Mar Public General	B	164	Specialist services general surgery, internal medicine, OB/GYN & paediatrics. Full array of laboratory, x-ray, nutrition and physiotherapy
SOUTHERN REGIONAL HEALTH AUTHORITY	St. Elizabeth	Black River	C+	100	Specialist services general surgery, internal medicine, OBGYN & paediatrics. Basic lab & x-ray
	Manchester	Mandeville	B+	220	Specialist services general surgery, internal medicine, OBGYN, orthopaedics, psychiatry& paediatrics. Full array of laboratory, x-ray, nutrition and physiotherapy
	Clarendon	May Pen	B	150	Specialist services general surgery, internal medicine, OBGYN, psychiatry& paediatrics. Full array of laboratory, x-ray, nutrition and physiotherapy
	Clarendon	Percy Junor	C+	119	Uncomplicated specialist services general surgery, internal medicine, OBGYN & paediatrics. Basic lab & x-ray
	Clarendon	Lionel Town	C	45	Uncomplicated and minimal inpatient and outpatient general medicine, paediatrics & OBGYN. Basic lab & x-ray

APPENDIX 5: PRIVATE HOSPITALS

PARISH	HOSPITAL
Kingston	St. Joseph
	Nuttall
St. Andrew	Andrews Memorial
	MedicalAssociates
	Tony Thwaites Wing
Manchester	Hargreaves Memorial
St. James	Montego Bay Hospital
	Hospiten Jamaica Ltd
	Doctors Surgi Clinic
Westmoreland	Royale Medical Centre
St. Ann	Medical Care and Surgical Centre

APPENDIX 6: REFERRAL FORM A

REFERRAL FORM A

TO BE COMPLETED IN TRIPLICATE

TREATMENT REQUIRED(TICK ONE BOX)

☐ Emergency ☐ Urgent ☐ Routine

When making a referral, please send both the white and blue copies of this form with the patient.

Part 1. TO BE COMPLETED BY PERSON REFERRING

TO:..... Date of Referral:.....Hosp/H.C. .....
Name or Position of Individual

FROM: ..... PARISH:.....
Health Facility/Dept/Staff

Patient Name: .....Medical Record No. .....

To be used for requesting, consultation, investigation, diagnosis treatment, admission.

Sex M □ F□ Date of Birth:..... / ...../ ..... Age:.....
DD MM YR

.....

Complaints/Findings: .....

.....

Investigations done and Results: .....

.....

Provisional Diagnosis:.....

Treatment given to date:.....

Reason for Referral:.....

Name of person referring patient: (Print) .....Status.....Signature.....

.....

PART II. TO BE COMPLETED BY RECEIVING HEALTH CARE FACILITIES/DEPARTMENT/STAFF AND RETURNED TO REFERRING HEALTH CARE FACILITY

Receiving Centre Medical Record No: .....
Complaints: .....
Findings: .....

Results of Investigation:.....

.....

Diagnosis : .....

TREATMENT GIVEN AT RECEIVING CENTRE: .....

Treatment to be given: .....

.....

Remarks/follow-up required:.....

.....

Patient to return in ..... Weeks/Months. Appointment not given/given date: .....

Attending Clinician (Print).....Signature.....

HEALTH CARE FACILITY:..... Date:.....

RETURN WHITE COPY WITH THE COMPLETED PART 2 TO REFERRING HEALTH CARE FACILITY

Do not remove upper portion of form

MR. 23a REV. 1/94

Use additional sheets if necessary.

INSTRUCTIONS FOR USE OF REFERRAL FORM A

Referral Form A is used to document all referrals between health centres; between hospitals and health centres; and between hospitals, for the purposes of requesting consultation, specialized investigation, diagnosis, treatment, admission and follow-up. ***Referral Form A*** is in triplicate, self-carboning and bound in book-form:

- The first copy is white
- The second copy is blue
- The third copy is pink

The healthcare professional referring the patient:

a. completes Part I of the form
b. removes the form from the booklet, then sends the white and blue copies with the patient to the receiving facility
c. The pink copy is retained in the **patient's medical records (docket)** at the referring facility and used for follow-up purposes

At the receiving facility:

a. Part II of ***Referral Form A*** on the white copy is completed by the primary/lead physician
b. At the end of treatment or as soon as a definitive diagnosis is made and treatment protocol established, the counter-referral is returned to the referring centre using the established Ministry of Health mailing system and by electronic means. A copy is also sent with the patient
c. The blue copy is retained as part of the patient's medical record at the receiving facility

Patient management is not considered complete until the counter-referral has been made (Part II of the white copy completed and returned) to the original referring healthcare provider.

WHO SHOULD COMPLETE REFERRAL FORM A

A. Part 1 of **Referral Form A** is to be completed by the healthcare professional making the referral, who should observe all principles as dictated in this document and have the following clearly documented:
   a. Patient complaints, pertinent findings, investigations and provisional diagnosis;
   b. Reason for referral and urgency;

c. Patient's name, pet name, gender, date of birth, age;
d. Patient's address, telephone number;
e. Name of referring institution, health professional and signature;
f. Date of referral.

B. Part II of ***Referral Form A*** is the counter-referral to be completed by the receiving healthcare specialist with primary / lead responsibility for the referred patient. The completed Part II of ***Referral Form A*** will:

a. Answer the questions of the person referring by indicating that the provisional diagnosis was correct or giving reasons for a change of diagnosis
b. Document the management of the patient at the receiving centre
c. Describe the most appropriate treatment protocol to be followed
d. Indicate if and when the patient should return to be seen at the receiving centre

The completed white copy is then returned to the healthcare provider/health facility from where the referral was made using the established Ministry of Health's mailing system and by electronic means. A copy is also sent with the patient. If the patient is to undergo lengthy admission or investigations, Part II of the Referral Form A should be completed and indicate that this is the case. When the patient is discharged from hospital, a copy of the discharge summary is also sent to the healthcare provider/health facility from where the referral was made using the Ministry of Health mailing system and by electronic means. A copy is also sent with the patient.

THE ROLE OF THE MEDICAL RECORDS PERSONNEL

The Medical Records personnel have an important role to play in ensuring all completed referral and other forms are appropriately filed in the patients' medical records. As well, they facilitate the return of the white copies of ***Referral Form A*** to the referring person / institution using the Ministry of Health's mailing system and by electronic means. A copy is also sent with the patient. The Medical Records personnel:

- Document the patients who have been referred and the service to which they have been referred;
- Ensure that Referral Form A is attached to the appropriate file;
- Follow-up to ensure that the white copy is completed for early and onward transmission to the healthcare provider/health facility from where the referral was initiated, and that the pink and blue copies are appropriately filed in the patients' records.

APPENDIX 7: REFERRAL FORM B

REFERRAL FORM B

TO BE USED FOR INTERDEPARTMENTAL REFERRALS & CONSULTATIONS

Please print all information

Hospital _____ **Ward** _____

Service required: **Emergency** ☐ **Urgent** ☐ **Routine** ☐

Patient name: _____ **Cas. No.** _____ **Record No.** _____

Age: _____ **Female** ☐ **Male** ☐

Referred to: _____ **Consultant/Clinic** **Department/Ward**

Referred for: **Appointment** ☐ **Admission** ☐ **Consultation** ☐

Diagnosis & other information:_____

_____

_____

Referred by: _____ **Date:** _____/_____/_____ **Time:**_____ **A.M/P.M**

CONSULTANT OPINION & RECOMMENDATION

Signature: _____ **Date:** _____/____/_____ **Time:**_____ **A.M/P.M**

Ref. 6(mr 27) rev 12/93 **Use over leaf if necessary**

An additional page can be added for more information.

INSTRUCTIONS FOR USE OF REFERRAL FORM B

Referral Form B should be used **within** the Types A, B, C and S hospitals. It should be used **exclusively** for intra-hospital referrals / consultations **only** and **not** for external referrals, for which ***Referral Form A*** applies. Referral Form B is used for the purpose of requesting consultation and investigation for diagnosis or treatment. The patients referred, are usually already registered in the current hospital. The referrals are:

1. From one in-patient specialist service to another
2. From one out-patient specialist clinic to another
3. From an out-patient clinic for admission
4. From A & E / Casualty, to a specialist clinic or for admission

REFERRAL FORM B IS A SINGLE SHEET WITH TWO SECTIONS:

a. The first section (top half) is to be completed by the referring doctor or other healthcare personnel as the specialty dictates
b. The second section (bottom half) is to be completed by the specialist healthcare personnel to whom the patient had been referred.

SECTION I OF REFERRAL FORM B

The doctor or other specialist referring the patient is responsible for ensuring that accurate information is documented in Section I of the form:

1. Patient complaints, pertinent findings, investigations and provisional diagnosis;
2. Reason for referral and urgency;
3. Patient's name, pet name, gender, date of birth, age;
4. Ward and specialty, name of consultant, referring health professional and signature;
   - ➢ In cases of emergency or urgent referrals, the senior resident on duty-call shall be alerted immediately of the referral and its nature;
   - ➢ Less urgent cases are usually referred for appointments through the specialist outpatient clinic.

SECTION 2 OF REFERRAL FORM B

The doctor, physiotherapist, nutritionist or other providing consultation should complete Section 2 of the form, sign and return to the referring doctor. It is essential, as it:

- ✓ May answer the questions of diagnosis.
- ✓ Provides the most appropriate recommendations on future patient management.

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