Standardising Patient Referral Information: a Draft National Template for Consultation

14 December 2010
About the Health Information and Quality Authority

The Health Information and Quality Authority is the independent Authority which has been established to drive continuous improvement in Ireland’s health and social care services. The Authority was established as part of the Government’s overall Health Service Reform Programme.

The Authority’s mandate extends across the quality and safety of the public, private (within its social care function) and voluntary sectors. Reporting directly to the Minister for Health and Children, the Health Information and Quality Authority has statutory responsibility for:

Setting Standards for Health and Social Services — Developing person centred standards, based on evidence and best international practice, for health and social care services in Ireland (except mental health services)

Social Services Inspectorate — Registration and inspection of residential homes for children, older people and people with disabilities. Inspecting children detention schools and foster care services. Monitoring day and pre-school facilities

Monitoring Healthcare Quality — Monitoring standards of quality and safety in our health services and investigating as necessary serious concerns about the health and welfare of service users

Health Technology Assessment — Ensuring the best outcome for the service user by evaluating the clinical and economic effectiveness of drugs, equipment, diagnostic techniques and health promotion activities

Health Information — Advising on the collection and sharing of information across the services, evaluating information and publishing information about the delivery and performance of Ireland’s health and social care services

The Health Information and Quality Authority is a signatory to Patient Safety First - an awareness raising initiative through which healthcare organisations declare their commitment to patient safety. Through participation in this initiative, those involved aspire to play their part in improving the safety and quality of healthcare services. This commitment is intended to create momentum for positive change towards increased patient safety.

1 Not all parts of the relevant legislation, the Health Act 2007, have yet been commenced.
Overview of Health Information function

Health is information-intensive, generating huge volumes of data every day. It is estimated that up to 30% of the total health budget may be spent one way or another on handling information, collecting it, looking for it, storing it. It is therefore imperative that information is managed in the most effective way possible in order to ensure a high quality, safe service.

Safe, reliable, healthcare depends on access to, and the use of, information that is accurate, valid, reliable, timely, relevant, legible and complete. For example, when giving a patient a drug, a nurse needs to be sure that they are administering the appropriate dose of the correct drug to the right patient and that the patient is not allergic to it. Similarly, lack of up-to-date information can lead to the unnecessary duplication of tests – if critical diagnostic results are missing or overlooked, tests have been repeated unnecessarily and, at best, appropriate treatment is delayed or at worst not given.

In addition, health information has a key role to play in healthcare planning decisions – where to locate a new service, whether or not to introduce a new national screening programme and decisions on best value for money in health and social care provision.

Under section (8)(1)(k) of the Health Act 2007, the Authority has responsibility for setting standards for all aspects of health information and monitoring compliance with those standards. In addition, under section 8(1)(j), the Authority is charged with evaluating the quality of the information available on health and social care and making recommendations in relation to improving the quality and filling in gaps where information is needed but is not currently available.

Information and communications technology (ICT) has a critical role to play in ensuring that information to drive quality and safety in health and social care settings is available when and where it is required. For example, it can generate alerts in the event that a patient is prescribed medication to which they are allergic. Further to this, it can support a much faster, more reliable and safer referral system between the patient's general practitioner (GP) and hospitals.

Although there are a number of examples of good practice, the current ICT infrastructure in Ireland’s health and social care sector is highly fragmented with major gaps and silos of information which prevents the safe, effective, transfer of information. This results in service users being asked to provide the same information on multiple occasions.

Information can be lost, documentation is poor, and there is over reliance on memory. Equally those responsible for planning our services experience great difficulty in bringing together information in order to make informed decisions.
Variability in practice leads to variability in outcomes and cost of care. Furthermore, we are all being encouraged to take more responsibility for our own health and wellbeing, yet it can be very difficult to find consistent, understandable and trustworthy information on which to base our decisions.

As a result of these deficiencies, there is a clear and pressing need to develop a coherent and integrated approach to health information, based on standards and international best practice. A robust health information environment will allow all stakeholders – the general public, patients and service users, health professionals and policy makers – to make choices or decisions based on the best available information. This is a fundamental requirement for a high reliability healthcare system.
Table of Contents

1. Introduction 6
2. Background 7
3. Consultation process 7
4. Methodology 8
5. Patient referral template 11
6. Patient Referral dataset 14
   6.1 Referral details 14
   6.2 Patient details 15
   6.3 Referrer details 19
   6.4 Patient’s usual GP 19
   6.5 Clinical information 20
   6.6 Hospital-use section 22
7. References 25
8. Glossary of terms and abbreviations 26

Appendices

Appendix 1 - Referral Project Advisory Group members 28
1. Introduction

General practitioners (GPs) are the gatekeepers between primary and secondary care, especially in non-critical or non-emergency situations and are often responsible for the decision to refer a patient to secondary or tertiary care. What this means in practice is that when a GP decides that a patient needs to see a consultant, information about the patient is sent to the hospital. It is essential that this information is accurate, relevant and complete and gets to the hospital on time.

The referral process requires the transfer of information which generally involves a referral document being sent from the GP to secondary care. This referral document can be in the form of a letter – handwritten or typed – or the completion of a referral form usually on paper but in a few cases electronic.

A timely, safe, effective, equitable and patient-centred referral process depends critically on the quality of the information which is provided in this referral document. Quality information is defined as information that is timely, complete, relevant, reliable and valid\(^1,2,3\).

The development of standardised patient referral information (containing a standardised referral dataset and template) is an important step towards improving the whole patient referral process and enabling the delivery of safe, person-centred care.

The benefit for patients is that patients with the most urgent needs will be identified more clearly because information sent from GPs to hospitals will be more complete, consistent, accurate and reliable. Incomplete information can cause delays in the referral process. As a result, the clinical information that consultants review about the patient will enable them to prioritise patients more effectively and accurately. To help improve services provided to patients the Health Information and Quality Authority (the Authority) has published this document, *Standardising Patient Referral Information: a Draft National Template for Consultation*, which clearly outlines what information should be contained in a patient referral letter between a GP and secondary or tertiary care.

The information required includes information to identify the patient, to ascertain if the patient has previously attended the hospital and contact information for both the referrer and the patient. Also required is high quality current and historical clinical information in order to assess the clinical problem in question and to assign a priority to the patient. The referral document is used in secondary care by a number of different individuals including clinical staff, medical records staff and administrative staff, and
therefore needs to meet all their diverse requirements for the provision of a timely, safe and efficient patient referral service.

2. Background

Arising from the issues relating to unreported radiology films and unprocessed GP referral letters in the Adelaide and Meath Hospital incorporating the National Children’s Hospital (AMNCH), Dublin, the Authority, in collaboration with the Irish College of General Practitioners (ICGP), is undertaking a project that is assessing current patient referral processes. The result of this project will include a set of recommendations for a consistent national approach to referrals that will improve the quality of care and access to services for patients. An Advisory Group with representatives from all the key stakeholders was established (see Appendix 1 for list of members) and to date it has met on two occasions.

This Standardising Patient Referral Information: a Draft National Template for Consultation forms one specific part of the project. This consultation process will inform this specific element of the overall project, and the final version of the referral template will be included in the final report of the project due to be published by the Authority in 2011. The final report will make recommendations and provide guidance on other aspects of the referral pathway including, but not limited to, the tracking and traceability of referrals. The recommendations and guidance contained in the final report will be linked to the final National Standards for Safer Better Healthcare to be published by the Authority in 2011. The draft of these standards, which was published by the Authority earlier this year, include the requirement for the active coordination of patient care between services and stipulate that the right information should be shared appropriately. This consultation document details the information that should be shared when a patient is being referred from primary care to secondary or tertiary care.

3. Consultation process

This document presents for public consultation a proposed standardised referral dataset and template. The Authority is fully committed to stakeholder consultation and values all feedback provided as part of its development process.

This document contains a number of consultation questions for you to consider - you’ll find them highlighted in boxes like this throughout the document. These questions can also be found in the Consultation Feedback Form which is available on www.hiaq.ie.
The Standardising Patient Referral Information: a Draft National Template for Consultation is available for public consultation for a five-week period. In this way, the public, service users and service providers will have the opportunity to provide feedback and participate in the development process. We invite all interested parties to submit their views on this document.

The closing date for receipt of comments is 12 noon on 21 January 2011.

How to make a submission

A number of consultation questions have been prepared for your consideration when reviewing this document. These questions are not intended, in any way, to limit feedback and any other comments are welcome.

There are several ways to tell us what you think:

Your comments can be submitted by downloading and completing the consultation feedback form available from www.hiqa.ie and emailing your completed forms to consultation@hiqa.ie.

You can print off a copy of the feedback form from our website and post it to us at:

Health Information and Quality Authority
Standardising Patient Referral Information
George’s Court, George’s Lane,
Smithfield, Dublin 7

For further information or if you have any questions, you can talk to the consultation team by calling (01) 8147681.

How we will use your comments

Following the consultation, the Authority will analyse the submissions and make further amendments to the document as appropriate. We wish to thank you in advance for taking the time to submit your comments.

4. Methodology

The methodology followed by the Authority has included an international review of best practice in patient referrals, a number of meetings with individuals and groups across the health sector with an interest/expertise in the referral process, and a series of discussion groups with GPs and hospital staff, both administrative and clinical. These groups discussed the current patient referral processes and identified areas of concern and suggested potential solutions. The details of the themes which emerged from that consultation phase will also be included in the final report. However, a
constant and recurring theme centred on the variety of different patient referral documents that are currently in use and the variability in the quality of information they contained.

There was universal agreement that the use of a standardised patient referral form, or a referral template, would be of great benefit to both GPs and hospital staff. In particular, templates help to ensure the completeness of the information by acting as a prompt to the referrer. They can also support the automatic population of the template from GP practice management software systems. The Advisory Group recommended that the Authority proceed with the development of a standardised referral form and data set, that is the data items to be included in the template.

Consultation Question 1

Do you feel there are benefits in having a standardised generic patient referral dataset and template, and, if so, what are the main benefits?

Currently, there is no nationally agreed generic patient referral dataset or template in use. There are no agreed datasets for patient identification, identification of referring doctor, or clinical information that should be sent when referring a patient. However, there are a number of different initiatives proposed or in use including, the standardised referral for the National Cancer Control Programme (NCCP) and the proposed electronic referral in the Health Service Executive (HSE) South region.

It was agreed to limit the scope of this element of the standardised patient referral information in the first instance to:

- GPs as the primary user of the template, with future development possibly including intra-hospital or inter-hospital referrals
- the dataset should include clinical and administrative data such as referral details, patient details, referrer details, clinical information and a hospital-use section
- the referral dataset and template should not replace the NCCP’s referral templates and datasets but should be closely aligned with them.

Certain design decisions and principles were agreed, namely:

- the potential for GP practice management software systems to automatically populate some fields in the template should be taken into account
- page numbers, patient name and GP name should be included on each page
formatting of the template should not be too prescriptive in order to allow flexibility, particularly for those GPs using practice management software systems to support the referral process

- mandated items in the dataset should be populated
- the grouping of clinical headings (such as family history/social history) may not be possible on the template as practice management software systems may not be able to support the population of a single heading from multiple data sources in the patient record
- the dataset and template should not contain information that the GP will have difficulty sourcing as this could delay the sending of the referral
- definitions of data items and their correct usage are required.

In addition to the discussion groups, the Authority has consulted widely, as noted above, and in particular has held detailed discussions with a number of individuals and groups who have carried out work on various aspects of the referral process. These include the National Cancer Control Programme, the General Practice Information Technology Group; Health One User Group; North East Outpatient Department (OPD) Group, OPD Data Quality Programme, and the Quality and Clinical Care Directorate of the HSE. In addition, the Authority has reviewed a number of locally developed and international templates. Based on this work, the Authority has developed the Draft National Standard for Patient Referral Information containing a standardised referral dataset and associated template, which are the subject of this consultation document.

It is anticipated that the referral template will be included in the national pilot of electronic referrals in the HSE South region.

The dataset and template are divided into six areas:

1. Referral details.
2. Patient details.
3. Referrer details.
4. Patient’s usual GP.
5. Clinical information.
6. A hospital-use section.

This document defines each of the data items and provides a suggested non-prescriptive layout for a standard patient referral template. Figure 1 on the next page presents the proposed referral data set. Note fields marked with an asterisk are mandatory.
**Figure 1. Draft referral dataset**

(* Denotes mandatory field)

### 5. Patient Referral template

The draft referral template is shown below in Figures 2 and 3. Note that the layout and format of the template is provided as a possible solution. However, it is strongly recommended for safety reasons that each page in any referral document should be numbered and that the patient’s name, date of birth and referring GP is included on each page.

**Consultation Question 2**

Is the layout of the template easy to use, either in paper format or embedded within a GP practice management system?
# National standardised patient referral template

## Referral details
- **Hospital:**
- **Specialty/directorate:**
- **Preferred consultant/healthcare practitioner:**
- **Reason for referral/comments:**
- **Priority (GP):**
- **Date of referral:**

## Patient details
- **Surname:**
- **First name:**
- **Address:**
- **Date of birth:**
- **Gender:**
- **Name of parent or guardian (if appropriate):**
- **Mobile number:**
- **Telephone (day):**
- **Telephone (evening):**
- **Hospital number:**
- **First language:**
- **Interpreter required:** □ Yes □ No
- **Special needs:** □ Yes □ No

## Referrer details
- **Name:**
- **Address:**
- **Telephone:**
- **Fax:**
- **Mobile:**
- **Signature of referrer:**
- **Medical Council registration number:**

## Patient’s usual GP (if different from Referrer details above)
- **Name:**
- **Address:**

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**Figure 2. Draft referral template, page 1**
## Clinical information

Symptoms (including history of presenting complaints and interventions to date):

---

Examination findings:

---

Relevant tests/investigations:  
- [ ] Attached  
- [ ] Not Applicable

---

Past medical history:

---

Current medication:

---

Adverse events/allergies:

---

Family history:

---

Social history:

---

## For hospital use (referral management and outcome)

<table>
<thead>
<tr>
<th>Date referral received:</th>
<th>Triage outcome (priority):</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>[ ] Urgent  [ ] Soon  [ ] Routine</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Date sent for triage:</th>
<th>Date of new attendance:</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Date returned from triage:</th>
<th>Consultant clinic:</th>
</tr>
</thead>
</table>

Patient’s name:  
Patient’s date of birth:  
Referring GP’s name:

---

**Figure 3. Draft referral template, page 2**
6. Patient referral dataset

The patient referral dataset consists of the following groupings of attributes: referral details, patient details, referrer details, patient's usual GP, clinical information and hospital-use sections.

Tables 1 to 6 on the following pages provide information on each of the data items using the headings name, definition, synonyms and usage. All data items are either required (mandatory) and should be included at the time of the referral, optional, or conditional e.g. based on patient consent.

### Consultation Question 3

Have all of the appropriate groupings of data items been included in the dataset? If not, what additional groupings should be added?

### Consultation Question 4

Have all of the appropriate data items been included in the data set? Which, if any, of the data items listed should be omitted? What additional data items, if any, should be added?

6.1 Referral details

The purpose of ‘referral details’ is to identify the hospital and the specialty/directorate to which the patient is being referred. The ‘preferred consultant’ information is not mandated but may be used by the referrer to identify their preference for a named consultant to see their patient. The complete address of the hospital is not required. The GP should also provide his/her assessment of the priority and use the ‘reason for referral’ section to indicate what is being requested from the specialty/directorate to which the referral is being directed.

**Table 1. Referral details data items**

<table>
<thead>
<tr>
<th>Name</th>
<th>Definition</th>
<th>Synonyms</th>
<th>Usage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital</td>
<td>A health facility providing secondary or tertiary care.</td>
<td></td>
<td>Required.</td>
</tr>
<tr>
<td>Specialty/Directorate</td>
<td>The directorate or specialty within the hospital to which</td>
<td>Clinical Directorate, Specialty, Consultant</td>
<td>Required.</td>
</tr>
</tbody>
</table>
### 6.2 Patient details

Accurate patient information is and all available information should be provided when creating a referral. These details enable the hospital to:

- correctly identify the patient
- identify whether the patient has previously attended the hospital
- initiate communication with the patient, and
- be aware of any special needs in advance of the patient attending the hospital.

<table>
<thead>
<tr>
<th><strong>Preferred consultant/Healthcare practitioner</strong></th>
<th>A named consultant to which the patient would like to be referred.</th>
<th>Optional. Used by the referrer to identify a named consultant to which the patient would like to be referred to.</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Reason for referral/Comments</strong></td>
<td>The referral reason.</td>
<td>Required. Please indicate succinctly what is being requested from the specialty/directorate to which the referral is being directed, for example, the action expected from the referral, the clinical question being asked, or the procedure being requested.</td>
</tr>
<tr>
<td><strong>Priority (GP)</strong></td>
<td>The referrer’s assessment of the urgency of this referral.</td>
<td>Required.</td>
</tr>
<tr>
<td><strong>Date of referral</strong></td>
<td>The date on which the referral was made. Date on the letter / fax / pro forma from referring GP.</td>
<td>Required.</td>
</tr>
<tr>
<td>Name</td>
<td>Definition</td>
<td>Synonyms</td>
</tr>
<tr>
<td>-----------------------------</td>
<td>-----------------------------------------------------------------------------------------------------------------------------------------------------</td>
<td>--------------------------------------------</td>
</tr>
<tr>
<td>Surname</td>
<td>The second part of a patient’s name which is used to describe their family or marital name.</td>
<td>Marital name, family name.</td>
</tr>
<tr>
<td>First name</td>
<td>A patient’s first name or given name, indicating the name they prefer to be identified by.</td>
<td>Forename, given name, Christian name.</td>
</tr>
<tr>
<td>Address</td>
<td>A composite of one or more address components that describe a low-level geographical/physical description of a location followed with the high-level address components i.e. suburb/town/locality name.</td>
<td>Residence, abode, home address, domicile.</td>
</tr>
<tr>
<td>Date of birth</td>
<td>Date of birth indicating the day, month and year when the patient was born.</td>
<td>D.O.B., born.</td>
</tr>
<tr>
<td>Gender</td>
<td>Gender identity is a person’s sense of identification with either the male or female sex, as manifested in appearance, behaviour, and other aspects of a person’s life.</td>
<td></td>
</tr>
<tr>
<td>Name of parent or guardian</td>
<td>The name of the parent or guardian, if appropriate.</td>
<td></td>
</tr>
<tr>
<td>(if appropriate)</td>
<td></td>
<td>Optional. Use of this field should be in line with appropriate standards, guidance and legislation.</td>
</tr>
<tr>
<td>Mobile number</td>
<td>The mobile telephone number of the patient. Inclusion of a patient’s mobile number should be agreed with the patient.</td>
<td></td>
</tr>
</tbody>
</table>

Inclusion of a patient's mobile number should be agreed with the patient.
<table>
<thead>
<tr>
<th><strong>Telephone (day)</strong></th>
<th>A telephone number for use during daytime other than the patient's mobile number which may be used to contact the patient. This may be a work telephone number or home telephone number and inclusion should be agreed with the patient.</th>
<th>Landline.</th>
<th>Conditional. In agreement with the patient, either a mobile number or a telephone number should be included. If the telephone number supplied is not the patient's own telephone number, the owner of that number should be informed of the referral.</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Telephone (evening)</strong></td>
<td>A telephone number for use during the evening time other than the patient’s mobile number which may be used to contact the patient. This may be a work telephone number or home telephone number and inclusion should be agreed with the patient.</td>
<td>Landline.</td>
<td>Conditional. In agreement with the patient, either a mobile number or a telephone number should be included. If the telephone number supplied is not the patient's own telephone number, the owner of that number should be informed of the referral.</td>
</tr>
<tr>
<td><strong>Hospital number</strong></td>
<td>A number or code assigned to an individual</td>
<td>Registration number,</td>
<td>Optional. This number should</td>
</tr>
<tr>
<td><strong>First language</strong></td>
<td>This is the primary language through which the patient communicates.</td>
<td>Principal language, spoken language, mother tongue.</td>
<td>Optional.</td>
</tr>
<tr>
<td>--------------------</td>
<td>-------------------------------------------------------------------------------------------------</td>
<td>-------------------------------------------------</td>
<td>----------</td>
</tr>
<tr>
<td><strong>Interpreter required</strong></td>
<td>An indicator to signify if an interpreter is required to allow the patient to communicate effectively within a healthcare setting.</td>
<td>Optional. Please indicate if verbal or non-verbal language interpretation is required. If so please provide details of the interpretation required.</td>
<td></td>
</tr>
<tr>
<td><strong>Special needs</strong></td>
<td>Individuals in need of additional assistance may include people with disabilities, or who live in institutionalised settings, are older people, are children, are from diverse cultures, or are disadvantaged in terms of transportation.</td>
<td>Optional. This section should contain relevant information relating to any special needs. Information regarding intellectual disabilities should be included in this section.</td>
<td></td>
</tr>
</tbody>
</table>
6.3 Referrer details

Referrer details consist of a set of attributes that accurately identify the referring healthcare practitioner.

**Table 3. Referrer details data items**

<table>
<thead>
<tr>
<th>Name</th>
<th>Definition</th>
<th>Synonyms</th>
<th>Usage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name</td>
<td>The referrer's first name and given name/surname.</td>
<td>Full name.</td>
<td>Required.</td>
</tr>
<tr>
<td>Address</td>
<td>A composite of one or more address components that describe a low-level geographical/physical description of a location followed with the high-level address components i.e. suburb/town/locality name.</td>
<td>Practice.</td>
<td>Required.</td>
</tr>
<tr>
<td>Telephone number</td>
<td>A telephone number other than the referrer's mobile number which may be used to contact the referrer.</td>
<td>Landline.</td>
<td>Conditional. Either the referrer's mobile number or telephone number should be included.</td>
</tr>
<tr>
<td>Fax</td>
<td>The fax number of the referrer.</td>
<td></td>
<td>Optional.</td>
</tr>
<tr>
<td>Mobile number</td>
<td>The mobile telephone number of the referrer.</td>
<td></td>
<td>Conditional. Either the referrer's mobile number or telephone number should be included.</td>
</tr>
<tr>
<td>Signature of referrer</td>
<td>The referrer's signature.</td>
<td></td>
<td>Required.</td>
</tr>
<tr>
<td>Medical Council registration number</td>
<td>The Medical Council registration number of the referrer.</td>
<td></td>
<td>Required if the referral originates from a medical practitioner.</td>
</tr>
</tbody>
</table>

6.4 Patient’s usual GP

This grouping should be completed if the referring healthcare practitioner is not the patient’s usual GP.
Table 4. Patient’s usual GP data items

<table>
<thead>
<tr>
<th>Name</th>
<th>Definition</th>
<th>Synonyms</th>
<th>Usage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name</td>
<td>The first name and given name/surname of the GP who usually provides services for the patient if the referrer is not the patient’s usual GP.</td>
<td></td>
<td>Optional. If the referrer is not the patient’s usual GP and knows who the patient’s usual GP is, it is recommended that this information is supplied.</td>
</tr>
<tr>
<td>Address</td>
<td>The address of the GP who generally provides services for the patient if the referrer is not the patient’s usual GP.</td>
<td></td>
<td>Optional. If the referrer is not the patient’s usual GP and knows who the patient’s usual GP is, it is recommended that this information is supplied.</td>
</tr>
</tbody>
</table>

6.5 Clinical information

Secondary care requires quality information in order to assess the clinical problem in question and assign a triage priority to the patient. This grouping defines a set of clinical headings relating to the problem in question including current and historical clinical information on the patient.

Table 5. Clinical details data items

<table>
<thead>
<tr>
<th>Name</th>
<th>Definition</th>
<th>Synonyms</th>
<th>Usage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Symptoms (including history of presenting complaint and interventions to date)</td>
<td>Characteristic manifestations of a psychological or medical condition that may be observable to others and/or can be described by the person who experiences them.</td>
<td>Indications.</td>
<td>Required.</td>
</tr>
<tr>
<td>Examination findings</td>
<td>A physical examination is an evaluation of the</td>
<td></td>
<td>Optional.</td>
</tr>
<tr>
<td>Section</td>
<td>Description</td>
<td>Optional Information</td>
<td></td>
</tr>
<tr>
<td>---------------------------------</td>
<td>--------------------------------------------------------------------------------------------------</td>
<td>----------------------------------------------------------------------------------------</td>
<td></td>
</tr>
<tr>
<td>Relevant tests/investigations to date</td>
<td>Any previous laboratory, radiology or diagnostic procedures that have been undertaken to aid in diagnosing the problem.</td>
<td>Optional.</td>
<td></td>
</tr>
<tr>
<td>Past medical history</td>
<td>Important for determining the risk factors for diagnosing, and treating a disorder. This section should include a comprehensive and relevant list of the patient's past medical history.</td>
<td>Optional.</td>
<td></td>
</tr>
<tr>
<td>Current medication</td>
<td>Medication that the patient is prescribed or taking at the time of the referral.</td>
<td>Optional. Please provide if appropriate. If the patient is not on medication at the time of the referral, please indicate this.</td>
<td></td>
</tr>
<tr>
<td>Adverse events/allergies</td>
<td>An abnormally high acquired sensitivity to certain substances or any harmful, unintended effect of a medication, diagnostic test, or therapeutic intervention. This section should include information about any previous allergies or adverse events known about the patient that may put the patient at risk.</td>
<td>Optional. Please provide if appropriate. If there are no known allergies or adverse reactions, please indicate this on the referral form.</td>
<td></td>
</tr>
<tr>
<td>Family history</td>
<td>A summary of diseases present in immediate blood relatives.</td>
<td>Optional.</td>
<td></td>
</tr>
<tr>
<td>Social history</td>
<td>A summary of lifestyle</td>
<td>Optional.</td>
<td></td>
</tr>
</tbody>
</table>
6.6 Hospital-use section

The Hospital-use section is an optional section and may be used by hospitals to record the progression of a referral through their referral management system. The data items in the Hospital-use section align with the OPD Data Quality Dataset developed by the Health Service Executive (HSE). All hospitals will be required to report their OPD activity using the OPD Quality Dataset from January 2011. Hospitals are free to use the section or not, depending on whether it supports their business processes.
### Table 6. Hospital-use data items

<table>
<thead>
<tr>
<th>Name</th>
<th>Definition</th>
<th>Synonyms</th>
<th>Usage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Date referral received</td>
<td>The date that the referral request is received by the provider. The date when letter/fax/electronic form is received.</td>
<td></td>
<td>Optional. Please note that this item is part of the HSE OPD Data Quality Dataset.</td>
</tr>
<tr>
<td>Date sent for triage</td>
<td>The date that the referral request is sent for triage by a healthcare clinician. Triage is defined as referral analysis and assignment to an urgency category.</td>
<td></td>
<td>Optional.</td>
</tr>
<tr>
<td>Date returned from triage</td>
<td>The date that the referral request is returned from triage by a healthcare clinician. Triage is defined as referral analysis and assignment to an urgency category.</td>
<td></td>
<td>Optional. Please note that this item is part of the HSE OPD Data Quality Dataset.</td>
</tr>
<tr>
<td>Triage outcome (priority)</td>
<td>The triaging healthcare practitioner’s assessment of the urgency of the referral.</td>
<td></td>
<td>Optional.</td>
</tr>
<tr>
<td>Date of new attendance</td>
<td>The date of the new attendance in outpatients.</td>
<td>First OPD appointment date, procedure date.</td>
<td>Optional. Please note that this item is part of the HSE OPD Data Quality Dataset.</td>
</tr>
<tr>
<td>Consultant clinic</td>
<td>The consultant with responsibility for the care of the patient.</td>
<td></td>
<td>Optional. Please note that this item is part of the HSE OPD Data Quality Dataset.</td>
</tr>
</tbody>
</table>

**Consultation Question 5**

Do the definitions provided in Tables 1 to 6 adequately explain each of the data items? If not, please suggest improvements.
Consultation Question 6

Does the usage information provided in Tables 1 to 6 clearly explain the proposed use of each of the data items? If not, please suggest improvements.

Thank you for taking the time to read this document. We look forward to receiving your comments.
7. References


(4) Health Service Executive. *OPD Data Set Definitions Version One Nov 2010*
8. Glossary of terms and abbreviations

**Complete:** the completeness of data refers to the extent to which the data collected matches the data set that was developed to describe a specific entity

**Data item:** a data item is a specific sub-component of a data set

**Data quality:** data quality refers to data that is fit for purpose and accurately represents the activity of an organisation. This generally accepted definition recognises that the quality of data is determined by the consumer who will ultimately decide if it is fit for whatever purpose it is intended. Data quality can be further defined by a set of attributes, namely dimensions, which describe different aspects of data that are considered important to the users.

**Data set:** a data set can be understood as a collection of similar data, sharing a structure

**General practitioner:** a physician whose practice consists of providing ongoing care covering a variety of medical problems in patients of all ages, often including referral to appropriate specialists

**Information and communication technology:** the tools and resources used to communicate, and to create, disseminate, store, and manage information

**Inter-hospital transfer:** the process of transferring a patient’s care within a hospital from one consultant to another

**Intra-hospital transfer:** the process of transferring a patient from one hospital to another

**Practice management software systems:** a computer programme that deals with the day-to-day operations of a medical practice. Such software frequently allows users to capture patient demographics, schedule appointments, capture clinical information and generate reports

**Primary care:** primary care is the term for the health services who act as a first point of consultation for all patients

**Relevant:** the relevance of data refers to the extent to which the data meets the needs of users
**Reliable:** the reliability of data refers to the extent to which data is collected consistently over time and by different organisations either manually or electronically.

**Secondary care:** medical care provided by a specialist or facility upon referral by a primary care physician that requires more specialised knowledge, skill, or equipment.

**Template:** a file that serves as a starting point for a new document.

**Tertiary care:** specialised medical services that involves advanced and complex procedures and treatments performed by medical specialists.

**Timely:** the timeliness of data refers to the extent to which data is collected within a reasonable time period from the activity or event and is available within a reasonable timeframe to be used for whatever purpose it is intended.

**Triage:** triage is defined as referral analysis and assignment to an urgency category.

**Valid:** the validity of data refers to data that has been collected in accordance with any rules or definitions that are applicable for that data.
Appendices

Appendix 1
Referral Project Advisory Group members

Dr Ciaran Browne, Health Service Executive
Dr Claire Collins, Irish College of General Practitioners
Dr Deirdre Mulholland, Health Information and Quality Authority
Dr Brian O'Mahony, General Practice Information Technology Group
Mr Eadhbhard Mulligan, Royal College of Surgeons in Ireland
Professor Jane Grimson, Health Information and Quality Authority
Brigid Doherty, Patient Representative, Patient Focus
Dr Joe Clarke, Health Service Executive
Dr Maria O'Mahony, Health Information and Quality Authority
Dr Marie Laffoy, National Cancer Control Programme
Mary O'Connell, Health Service Executive
Nora Geary, Health Service Executive
Dr Peter Kavanagh, Faculty of Radiologists in Ireland
Ross Hattaway, Department of Health and Children
Dr Kevin O'Carroll, Health Information and Quality Authority
Professor Seamus Sreenan, Royal College of Physicians of Ireland