How to Write So Consultants will Listen

The art of the referral request letter

Dr Kate Miller, CPFC, Guelph, ON
Dr Lesley Barron, FRCS, Georgetown, ON

1

Faculty Disclosure

- Neither Dr Barron nor Dr Miller have any conflicts of interest to declare, financial or otherwise

2

THANKS

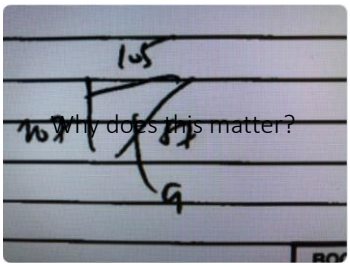
3

Objectives

At the end of this session, participants will be able to:

1. write consult request letters that clearly communicate the consultation question and urgency of request.
2. identify the information that consultants require to properly triage and book a consultation.
3. tailor the amount of information contained in the consultation request to the situation.

4



Hemant Shah
@hopetoMD

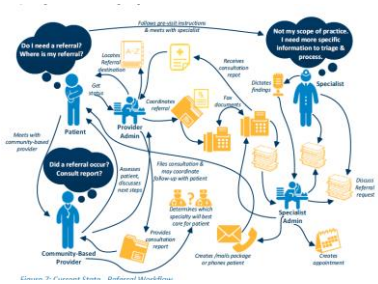
5

https://gregswings.ca/fttc-trailer/

6

OntarioMD, Provincial eReferral Initiative Business Case, April 28, 2017 – v0.7

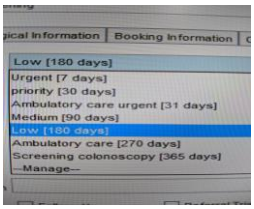
7



OntarioMD, Provincial eReferral Initiative Business Case, April 28, 2017 – v0.7

8

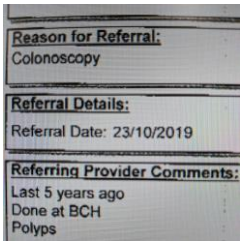
Referral booking system



- Every elective referral triaged
- If not enough information provided (or conflicting info) cannot triage safely or accurately

9

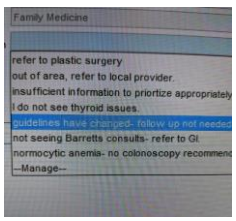
Triage information



- Accurate triage improves outcomes
- Pertinent info- negative and positive

10

Referral rejection



- Small sample
- Easier to send referral than ask the question
- Rejection should be timely (14 days), suggest alternate
- Rejection due to wait times
- Expertise deficit

11

Requirements of the referral process - CPSO Policy on Transitions of Care, 2019

- Both referring and consultant physicians must clearly communicate to patient their role and the limits of their care
- Referring physicians MUST have a method for tracking urgent referrals, should have one for all referrals
- Consultant physicians must acknowledge referral within 14 days, including indicating whether or not the referral is accepted
  - If accepting either a date or anticipated wait time must be communicated
  - If declined, a reason for declining MUST be included

https://www.cpso.on.ca/Physicians/Policies-Guidance/Policies/Transitions-in-Care

12

Requirements of the referral process - CPSO Policy on Transitions of Care, 2019

- Referring physicians **must** make a referral request in writing and include the information necessary for the consultant health-care provider to understand the question(s) or issue(s) they are being asked to consult on.

https://www.cpso.on.ca/Physicians/Policies-Guidance/Policies/Transitions-in-Care

13

Requirements of the referral process - CPSO Policy on Transitions of Care, 2019

- While physicians **must** use their professional judgment to determine what information to include in the referral request, typically this will include:
  1. Patient, referring physician, and, if different, primary care provider identifying information;
  2. Reason(s) for the consultation and any information being sought or questions being asked;
  3. The referring physician's sense of the urgency of the consultation; and
  4. Summary of the patient's relevant medical history, including medication information and the results of relevant tests and procedures.

https://www.cpso.on.ca/Physicians/Policies-Guidance/Policies/Transitions-in-Care

14

Before you start

- What is the goal of the referral? The question to be answered?
- Have you done all the reasonable first steps?
- Is in person assessment the best way to achieve your goal/patient goal?
- What alternatives do you have
- It doesn't have to be hard

15

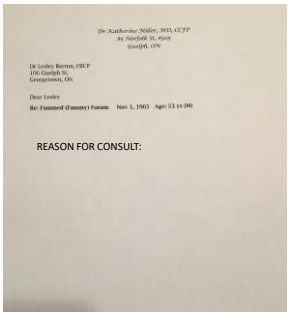
Structure/essential elements

1. Demographics – patient, referring physician, consultant
2. Clear consult question
3. Urgency of referral
4. Summary of problem to date.
5. Summary of investigations and treatments to date
6. Past medical history
7. Relevant Social history
8. Medication List
9. Summary and expectations

16

The consult question

- Most important piece
- Clear, concise summary of the issue with a clear ask
- Say “chronic hemorrhoids for consideration of banding” not “hemorrhoids”



Dr Katherine Miller, MD, CCFP
89 Norfolk St, #305
Guelph, ON

Dr Lesley Barron, FRCP
100 Guelph St,
Georgetown, ON

Dear Lesley

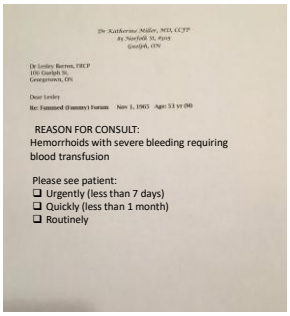
Re: Fummed (Fummy) Forum Nov 1, 1965 Age: 53 yr (M)

REASON FOR CONSULT:

17

The urgency of the question

- Don’t only indicate urgency but make sure the information provided supports the requested urgency
- Just make a call when you want someone seen quickly



Dr Katherine Miller, MD, CCFP
89 Norfolk St, #305
Guelph, ON

Dr Lesley Barron, FRCP
100 Guelph St,
Georgetown, ON

Dear Lesley

Re: Fummed (Fummy) Forum Nov 1, 1965 Age: 53 yr (M)

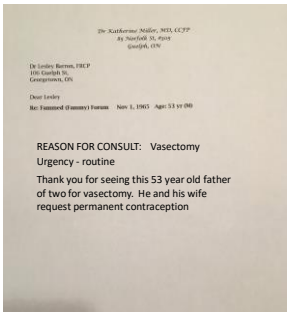
REASON FOR CONSULT:
Hemorrhoids with severe bleeding requiring blood transfusion

Please see patient:
- ❑ Urgently (less than 7 days)
- ❑ Quickly (less than 1 month)
- ❑ Routinely

18

Problem summary

- Brief summary of the issue or course to date
- For a simple referral, this can be very simple



Dr Katherine Miller, MD, CCFP
89 Norfolk St, #305
Guelph, ON

Dr Lesley Barron, FRCP
100 Guelph St,
Georgetown, ON

Dear Lesley

Re: Fummed (Fummy) Forum Nov 1, 1965 Age: 53 yr (M)

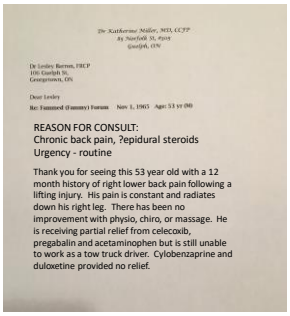
REASON FOR CONSULT: Vasectomy
Urgency - routine

Thank you for seeing this 53 year old father of two for vasectomy. He and his wife request permanent contraception

19

Problem summary

- Brief summary of the issue or course to date
- Timeline, therapies



Dr Katherine Miller, MD, CCFP
89 Norfolk St, #305
Guelph, ON

Dr Lesley Barron, FRCP
100 Guelph St,
Georgetown, ON

Dear Lesley

Re: Fummed (Fummy) Forum Nov 1, 1965 Age: 53 yr (M)

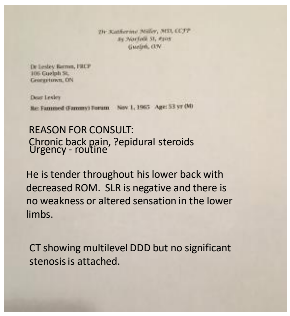
REASON FOR CONSULT:
Chronic back pain, ?epidural steroids
Urgency - routine

Thank you for seeing this 53 year old with a 12 month history of right lower back pain following a lifting injury. His pain is constant and radiates down his right leg. There has been no improvement with physio, chiro, or massage. He is receiving partial relief from celecoxib, pregabalin and acetaminophen but is still unable to work as a tow truck driver. Cylobenzaprine and duloxetine provided no relief.

20

Problem summary

- Brief summary of the issue or course to date
- Timeline, therapies
- Summarize physical findings
- Pertinent investigations



Dr Katherine Miller, MD, CCFP
85 Norfolk St, #305
Guelph, ON

Dr Lesley Barron, FRCP
106 Guelph St,
Georgetown, ON

Dear Lesley

Re: Fammed (Fammy) Forum   Nov 1, 1965   Age: 53 yr (M)

REASON FOR CONSULT:
Chronic back pain, ?epidural steroids
Urgency - routine

He is tender throughout his lower back with decreased ROM. SLR is negative and there is no weakness or altered sensation in the lower limbs.

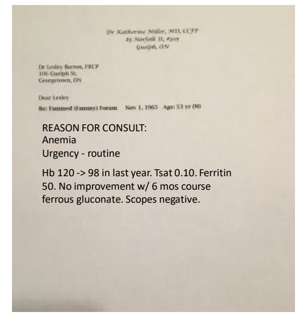
CT showing multilevel DDD but no significant stenosis is attached.

21

Problem summary

- Brief summary of the issue or course to date
- Timeline, therapies

Menaka Pal
@MPalMD



Dr Katherine Miller, MD, CCFP
85 Norfolk St, #305
Guelph, ON

Dr Lesley Barron, FRCP
106 Guelph St,
Georgetown, ON

Dear Lesley

Re: Fammed (Fammy) Forum   Nov 1, 1965   Age: 53 yr (M)

REASON FOR CONSULT:
Anemia
Urgency - routine

Hb 120 -> 98 in last year. Tsat 0.10. Ferritin 50. No improvement w/ 6 mos course ferrous gluconate. Scopes negative.

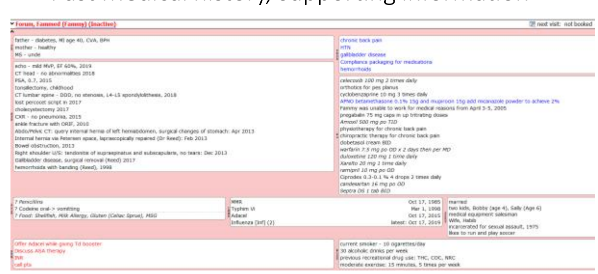
22

Problem summary

- Are there important facts that patients are likely to be unable to report?
- Things they might be unwilling to report?

23

Past Medical history, supporting information



Forum, Fammed (Fammy) (inactive)   next visit: not booked

father - diabetes, MI age 40, CVA, BPH
mother - healthy
MS - uncle

echo - mild MVP, EF 60%, 2019
CT head - no abnormalities 2018
PSA, 0.7, 2015
tonsillectomy, childhood
CT lumbar spine - DDD, no stenosis, L4-L5 spondylolithesis, 2018
lost percocet script in 2017
cholecystectomy 2017
CXR - no pneumonia, 2015
ankle fracture with ORIF, 2010
Abdo/Pelvic CT: query internal hernia of left hemiabdomen, surgical changes of stomach: Apr 2013
Internal hernia via Petersen space, lapraoscopically repaired (Dr Reed): Feb 2013
Bowel obstruction, 2013
Right shoulder U/S: tendonitis of supraspinatus and subscapularis, no tears: Dec 2013
Gallbladder disease, surgical removal (Reed) 2017
hemorrhoids with banding (Reed), 1998

chronic back pain
HTN
gallbladder disease
Compliance packaging for medications
hemorrhoids

celecoxib 100 mg 2 times daily
orthotics for pes planus
cyclobenzaprine 10 mg 3 times daily
APNO betamethasone 0.1% 15g and mupirocin 15g add miconazole powder to achieve 2%
Fammy was unable to work for medical reasons from April 3-5, 2005
pregabalin 75 mg caps m up titrating doses
Amoxil 500 mg po TID
physiotherapy for chronic back pain
chiropractic therapy for chronic back pain
clobetasol cream BID
warfarin 7.5 mg po OD x 2 days then per MD
duloxetine 120 mg 1 time daily
Xarelto 20 mg 1 time daily
ramipril 10 mg po OD
Ciprodex 0.3-0.1 % 4 drops 2 times daily
candesartan 16 mg po OD
Septra DS 1 tab BID

? Penicillins
? Codeine oral-> vomiting
? Food: Shellfish, Milk Allergy, Gluten (Celiac Sprue), MSG

MMR	Oct 17, 1985
Typhim Vi	Mar 1, 1998
Adacel	Oct 17, 2015
Influenza [Inf] (2)	latest: Oct 17, 2019

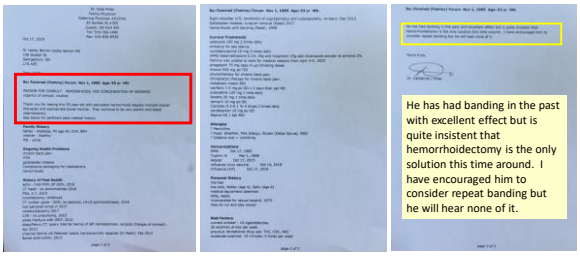
married
two kids, Bobby (age 4), Sally (Age 6)
medical equipment salesman
Wife, Habib
incarcerated for sexual assault, 1975
likes to run and play soccer

Offer Adacel while giving Td booster
Discuss ASA therapy
INR
call pts

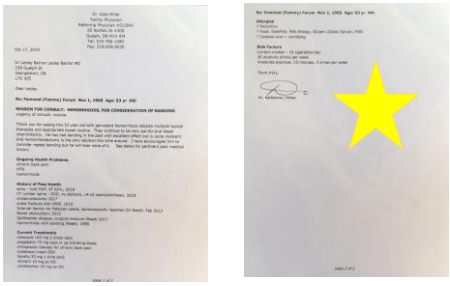
current smoker - 10 cigarettes/day
30 alcoholic drinks per week
previous recreational drug use: THC, COC, NRC
moderate exercise: 15 minutes, 5 times per week

24

Past Medical history, supporting information



25



26

Summary and next steps

- Is this a request for opinion or a transfer of care
  - *"I appreciate your opinion on how long to continue dual antiplatelet therapy"* vs *"please see for ongoing monitoring and management of his cardiac disease"*
- Recognize that patient won't be seen right away
  - Can you facilitate the consult by setting things up ahead of time
  - *"I have not ordered a CT scan but if you think it would be helpful I am happy to arrange in advance of the consultation"*
  - What are you doing to monitor or manage during the wait time
- Don't be afraid to include your diagnostic impression
  - *"I suspect the cause of his problems is irritable bowel syndrome but I wonder, given the atypical age of onset, whether a scope is indicated"*

27

Are things Changing?

- Don't be afraid to update, request things be moved up
- Forward interim investigations
- Send update letters
- Duplicate referrals (from emergency room/urgent care/walk-in visits)

28

Templates and checklists

FOR REFERRING PHYSICIANS - Referral Letter

Saskatchewan Quality Referral Pocket Checklist

PATIENT: Name, DOB, HSN, Gender, Address, Phone, Alternate contact, Translator required

PRIMARY CARE PROVIDER: Name, Phone, Fax, CC/ Indicate if different from family physician

REFERRING PHYSICIAN: Name, Phone, Fax

CLEARLY STATE REASON FOR REFERRAL

- Diagnosis, management and/ or treatment
- Procedure issue/care transfer
- Is patient aware of reason for referral?

SUMMARY OF PATIENT'S CURRENT STATUS

- Stable, worsening or urgent/emergent
- What do you think is going on?
- Symptom onset / duration
- Key symptoms and findings / any red flags

RELEVANT FINDINGS AND/OR INVESTIGATIONS *(pertinent results attached)*

- What has been done and is available
- What has been ordered and is pending

CURRENT AND PAST MANAGEMENT *(list with outcomes)*

- None
- Unsuccessful/successful treatment(s)
- Previous or concurrent consultations for this issue

COMORBIDITIES

- Medical history
- Pertinent concurrent medical problems (List other physicians involved in care if long-term conditions)
- Current and recent medications (name, dosage, PRN basis)
- Allergies/ Warnings and challenges

Adapted with permission from Quality Referral Evolution (QuRE) Working Group, Alberta

FOR SPECIALISTS - Consult Notes

Saskatchewan Quality Consult Pocket Checklist

PATIENT: Name, DOB, HSN, Gender, Address, Phone, Alternate contact, Translator required

REFERRING PROVIDER: Name, Phone, Fax, CC/ Indicate if different from family physician

CONSULTING PROVIDER: Name, Phone, Fax

PURPOSE OF CONSULTATION

- Date referral received and date patient was seen
- Diagnosis, management and/or treatment
- Procedure issue / care transfer / urgency

DIAGNOSTIC CONSIDERATIONS

- What do you think is going on? *(definitive/ provisional/ differential)*
- Why? *(explain underlying reason)*
- What else is pertinent to management?

MANAGEMENT PLAN

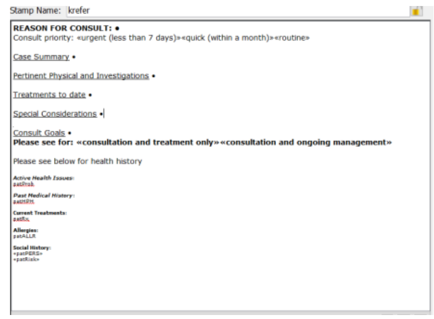
- Goals and options for treatment and management
- Recommended treatment and management
  - *rationale anticipated benefits and potential harms*
  - *contingency plan for adverse event(s) / failure of treatment*
- Advice given / Action(s) taken
- Situation(s) that may prompt earlier review

FOLLOW-UP ARRANGEMENTS *(who does what, when)*

- Indicate designated responsibility for:
  - *organizing reassessment and suggested time frames*
  - *medication changes (clarify if done or suggestion only)*
- Further investigations
  - *recommendations*
  - *responsibility for ordering, reviewing and notifying patient*

**Saskatchewan Ministry of Health March 2018*

29



Stamp Name: krefer

REASON FOR CONSULT: •
Consult priority: «urgent (less than 7 days)»«quick (within a month)»«routine»

Case Summary •

Pertinent Physical and Investigations •

Treatments to date •

Special Considerations •

Consult Goals •
Please see for: «consultation and treatment only»«consultation and ongoing management»

Please see below for health history

Active Health Issues:
patProb

Past Medical History:
patHPH

Current Treatments:
patRx

Allergies:
patALLR

Social History:
«patPERS»
«patRisk»

30

It's more than words….

- What would you say in person? If staff assigned to do referrals, can they communicate adequately?
- What does consultant need to know about this patient's story? (ie cancer anxiety)
- Econsults- often much more information provided from referrer when assumption made patient will not necessarily be seen in person.
- How do you and your staff decide who to refer to?

31

Using referrals to maintain good relationships with consultants

- We want the specialist to welcome our referrals
- Matching patient need to consultant scope/expertise/manner is important but difficult
- Consider if your referral patterns are subject to bias
  - Gender bias, stage-of-career bias, cultural bias
- Consider if you and your staff are in a referral rut
  - Send consultants a case mix of routine/urgent, challenging/routine, grunt work/easy work
- Recognize that we don't always know what they do JUST ASK

32

We want the consultant to think well of us

- Showing our knowledge, skill, limits through the letter
- Explain why you a referring a patient that on the surface looks like you should be able to manage yourself
- There should be no surprises
- Don't fudge the history to get someone seen quicker
- Be careful of the shot gun approach – referring to 10 people and taking the first available (centralized referral would really help reduce this)

33

No surprises

- If this is a second (or 3rd, 4th) opinion, call it such
- Be honest about third party requests, legal issues, WSIB
- Highlight the important things (eg blood thinners) that might not be picked up in review of PMHx
- Special considerations
  - Language issues
  - Hearing, vision, cognitive impairments
  - Mobility or transport issues

34

It is a two-way street…and a roundabout

- Cherry picking is a frustrating practice, may be justified in some circumstances (academic)
- Need communication (written, verbal) going both ways
- Refusing referrals against policy (culture eats policy for breakfast)
- Lots of the issues around referrals solved by centralized referrals
- Opinion- centralized referrals are coming- DAP clinics, cancer care, bariatric, academic centres.
- Disappointing but not surprising that colleges now involved in crafting policy around referrals for both referring and consulting physicians

35

Ways to cultivate relationship

- Econsult
- Phone calls
- Medical social events
- Local talks
- SoMe

36

Can technology save us?

- E-referral
  - Shared access to information eliminates duplication of testing and delays while acquiring more information
- Centralized referral
  - Eliminates shot gun approach
  - Eliminates delays due to too busy/out of scope/out of region etc
  - Already happens in many circumstances- DAP, cancer care, bariatrics, etc
- Imbedded forms of messaging/chat

37

Summary

- A clear, well written referral request doesn't take make time or effort but can make care so much better
- This is an important topic which deserves more attention
- Current referral system is not an optimal use of resources
- Referral system has failed to adapt to change
- Need to work within current system while advocating for change to ensure better outcomes in the future for patients, primary care providers, and consultants.
- For the time being- use referrals to reach out and connect with your colleagues- not only improves care but insulates against burnout.

38

Questions/Comments

Dr Kate Miller
drkjmiller@yahoo.ca
@DrKateJMiller

Dr Lesley Barron
lesley@drlesleybarron.com
@drlesleybarron

39