DEDER GENERAL HOSPITAL

LIAISON AND REFERRAL SERVICES PROTOCOL

PREPARED BY*: *HSQU

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PROTOCOL APPROVAL SHEET

NAME OF PROTOCOL: LIAISON AND REFERRAL SERVICES PROTOCOL

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Acronym

A&D	Admission and Discharge
EDD	Estimated day of discharge
EHRIG Guideline	Ethiopian Hospital Reform Implementation
FMOH	Federal Ministry of Health
HR	Human Resource
KPI	Key Performance Indicator
MOU	Memorandum of Understanding
M&E	Monitoring and Evaluation
OR	Operation Room
SMT	Senior Management Team
TWG	Technical Working Group
MRN	Medical Record numbe

1. Introduction

Referral is a process by which a health worker transfers the responsibility of care temporarily or permanently to another health professional or social worker or to the community in response to its inability or limitation to provide the necessary care. Referral is a two-way process and ensures that a continuum of care is maintained to patients or clients. It is done from the community to the primary care health service and to hospitals and within hospitals and vice versa. It also involves not only direct patient care but support services such as transport and communication. A referral may be for temporary, permanent or partial transfer of responsibility for the care of a patient. A referral system entails the interrelationships and coordination of patient care services from one health care hospital to another. The referral process begins by the referring health professional communicating to the receiving health professional or specialist relevant patient information. The receiving health professional communicates back to the referring health professional with information and plan for continuum of care thereby completing the referral process.

Referral can be vertical as in the hierarchical arrangement of the health services from the lower end of the health tier system to the higher ones. It also can be horizontal between similar levels of facilities in the interest of patients for cost, location and other reasons. Referrals can also be diagonal when a lower-level health hospital directly refers patients to a specialized hospital without necessarily passing through the hierarchical system

Objective of the Protocol

- For creating or improving liaison services and that of the referral network so that effective utilization of health care services resources to ensure provision of better quality of care.

Scope

- All liaison officers, health service providers, hospital managers and other stake holders.

Definition of Key Terms

- **Initiating hospital**: is the hospital that starts the referral process and they prepare an outward referral to communicate the client condition and status.
- **Receiving hospital**: is the hospital that accepts the referred case, and at the end of their involvement, they prepare a back referral/fed back on the lower part of the forms to let the initiating hospital know what has been done (see sample tool 1). This completes the referral loop between the 2 facilities.
- **Referral network:** is a patient flow system among geographically localized health service and health related service providing facilities upon referral of a patient.
- **Referral in: A**re those cases, which are accepted by the receiving hospital
- **Referral outs: A**re those cases referred to other facilities by the initiating facilities.
- **Liaison: A** person that liaises/connects between two or more service providers

Rationale for establishing referral System and liaison service

An effective referral system ensures a close relationship between all levels of the health system and helps to ensure people receive the best possible care closest to home in timely manner. It also assists in making cost-effective use of hospitals and primary health care services. Support to health centers and outreach services by experienced staff from the hospital or district health office helps build capacity and enhance access to better quality of care. Moreover, it reduces patient overcrowding at secondary and tertiary level facilities. Studies have shown that in many developing countries, a high proportion of clients seen at the outpatient clinics at secondary facilities could have been appropriately looked after at primary health care centers at lower overall cost to the client and the health system.

A good referral system can help to ensure:

- Clients receive optimal care at the appropriate level and not unnecessarily costly
- Hospital facilities are used optimally and cost-effectively
- Clients who most need specialized services can access them in a timely way
- Primary health services are well utilized and their reputation is enhanced

Reasons for Referral

- Reasons for referral should be medical, objective and in the best interest of the patient or client.

The following are considered good reasons for referrals:

- ✓ When a patient needs an expert advice as determined by the attending health professional
- ✓ When technical examination is required that is not available at the referring hospital
- ✓ When a technical intervention that is beyond the capabilities of the hospital is required
- ✓ When patients require inpatient care that cannot be given at the referring hospital
- ✓ When the referring hospital cannot no more accept patients due to shortage of beds and unavailability of professionals

Referrals are also made to the lower-level health facilities and community-based organizations in the best interest of the patient depending on: The condition of the patient. The capacity of the lower-level health hospital /community-based organization.

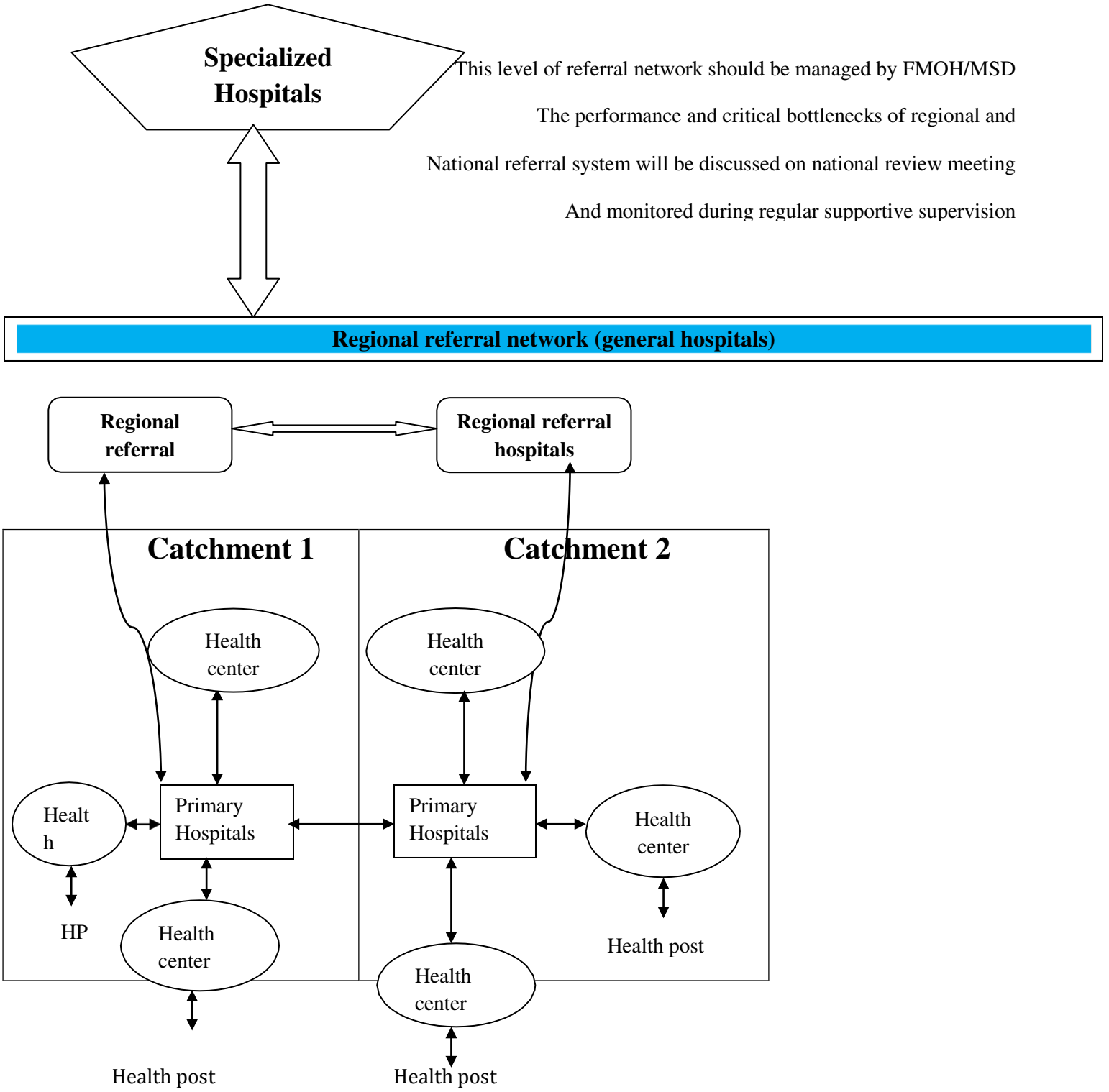
Rationale for establishing a liaison service

Liaison service is need for effective communication and sustainable and smooth flow of patients that need to be operated by liaison officers with special training for the position.

Generally, a liaison service aims at:

- Establishing and maintaining an effective liaison network with pertinent institutions and the public to achieve the best utilizations of resources
- Disseminating information and monitoring feedback- to ensure continuous improvement
- Organizing awareness creation programs- to ensure proper use of the service or the system
- Perform emergency liaison duties during mass casualties such as, flooding, fire, industrial accidents, etc a Liaison Officer is thus a person that runs the liaison services and liaises between two or more organizations and the public to communicate and coordinate their activities.

National Referral Network Model



Benefits of Good Referral System

A good referral system: -

- Increases the efficiency of the health system by maximizing the appropriate use of health care facilities.
- Strengthens the peripheral health facilities and improves the decision-making capacity of professionals at the lower level of the referral network.
- Creates opportunities for balanced distribution of funds, services and professionals while at the same time improving the effectiveness of the health system, and
- Helps to promote cooperation among primary, secondary and tertiary levels of care.

Roles and Responsibilities with regard to liaison service

a. Responsibilities of Senior Management Teams (SMT)

- Establish liaison office as per the standard.
- Monitor emergency liaison service as per the EHSIG
- Ensure that there is hospital - wide communication and staff awareness of this reference document, including student practitioners.
- Using these reference documents as minimum requirement develops tailored document for the hospital.
- Organize awareness creation programs to general public to ensure proper use of the service or system.
- Facilitate referral at hospital level so as to help in identifying the gaps in referral coordination at hospital level and to support the facilities in filling those identified gaps.
- Develop mechanism to monitor referral feedback.
- Ensure that referred patient s received service from a health professional at higher level than the one who referred the patient.
- Prepare hospital specific A & D protocol based on the national A& D

protocol.**

b. Roles and Responsibilities of Liaison officers

1. Update the elective admissions waiting list.
2. Assign an admission date to patients based on the urgency of the clinical need as date indicated by the physician in the patient notes.
3. Secure a bed for the patient.
4. Maintain good communications with inpatient case teams and the wards.
5. Ensure that the patient receives proper directions to the ward.
6. In collaboration with ward staff play a leading role in the co-ordination of discharges.
7. Ensure regular bed census is carried out, reported and used to update and manage the bed utilization.
8. Coordinate the overall referral activities.

Referral service

- Referral Service components
  1. Receiving Inpatient Referrals
  2. Coordinating Referral out Cases
  3. A feedback loop to track referrals

1. Receiving Inpatient Referrals

A. Emergency Referral in

- Each day, (**every 8 hours**) the liaison officer should asses the number of **unoccupied beds**, **number of patients in the emergency unit**/department waiting to be transferred to inpatient wards, and **number of patients in the ICU** to be transferred to the ward.
- If **dispatch/command center** is available, the liaison officer has to give report on vacant beds **three times a day** to the center and update information of the particular day.
- If the service is not available direct communication will be made between health institutions.
- Ensure the ambulance service is in place for 24 hour and is equipped with the

necessary medical supplies for critical emergency patients.

- **When a hospital calls to refer emergency cases a liaison officer should check the following things before accepting the referral:**

1. The availability of beds in the case team where the patient requires service
2. The availability of the service and professional (some service can be given by a highly trained individual professional; in such case the liaison should check the presence of the professional and the service).
3. Appropriateness of the referral, that is, the referral should be based on the referral network and any referrals should not be out of the referral network agreement, or the importance has to be justified with a discussion with the accepting physician.
4. Information on the patient's clinical condition, to ensure safe transportation and to consider patient is accompanied by a professional who has lifesaving skills.
5. Inform the accepting unit about the incoming patient's status, and the estimated time of arrival to the unit so that the accepting unit will make the necessary arrangements accordingly.

B. Cold Cases Referral in

- When a hospital calls to refer a non-emergency case that needs admission, the liaison should check the appropriateness of the referral (the same procedure listed above) and the nature of the disease in case the waiting time is becoming prolonged.
- This information helps to identify the disease progress such as if cancer is diagnosed at its early stage and prolonged appointment may lead for worsening of the diseases, therefore this information will help to prioritize admissions.
- There could be arrangement of elective admission date and inform the patient through the referring liaison officer.
- A liaison should present the elective admission list to inpatient case team on regular base preferably on **daily bases.**

C. Receiving Outpatient Referrals

- When a hospital calls to refer outpatient referrals a liaison should confirm the appropriateness of the referral, nature of the illness and arranges appointment date

and passes the information through the referring liaison officer.

- The liaison should present the **outpatient attendances** to outpatient department on regular bases.

Coordinating Referral out Cases

A. Emergency Referral Out

Once the Clinician has decided to refer out a patient the case should be immediately linked to liaison office. Before referring out a patient a liaison officer should:

- ☞ Check referral format is completely filed and signed by the physician.
- ☞ If there is a command center in the region the liaison should contact the command center to get appropriate receiving hospital.
- ☞ Use the service directory and the regional referral network to find appropriate hospital.
- ☞ Send one copy with the patient and attaching one to the patient medical record.
- ☞ Before sending any referral out the liaison officer should ensure bed and service availability at receiving hospital.
- ☞ The liaison office should insure that the patient has a necessary transport to reach the receiving unit, making use of the hospital vehicles/ambulance and professional attendance if it is essential.
- ☞ Register the patient on referral register (sample on annex).
- ☞ If the liaison officer can‟t find the service or the bed to refer the patient, the patient should stay in the hospital with available care until the liaison gets the needed service.
- ☞ If the patient is very sick and there are no beds in the receiving institutions the liaison officer has to facilitate online consultation service or has to facilitate communication between referring and receiving doctors/professionals for better management and facilitation.
- ☞ If there is any critical or unstable patient that needs admission/stay referral

should be made after communication with the referring and receiving physicians/health workers /so that patient transfer is made safely and proper arrangement for the patient management is done.

- ☞ Both the referring and receiving health institution liaison officers should make sure critical patients are transported safely and accompanied by professionals who have lifesaving skills.

B. Cold Cases Referral Out

After checking all necessary steps listed above and identifying appropriate hospital the liaison officer should communicate with receiving hospital liaison officer to pass the appointment information to the patient.

A feedback loop to track referrals

- A system to track a referral from point of initiation to point of delivery and, as a feedback loop, from point of service delivery back to point of initiation is needed to ensure that the client is using the service(s) needed.
- It is clear that the capacity of the lower-level health facilities has a great impact on overall health delivery system of a country; in particular the referral linkages of the health delivery system. Feedback and communication in the referral system is a critical step in addressing capacity issues. In addition, effective communication facilitates learning and, can inform professionals about the outcomes of the patients that they refer.
- Written feedback provides evidence that the referral process was completed and the service was delivered, and should indicate whether there were problems. Using the original referral request, documenting the status of service delivery and other pertinent information and returning the form to the site of referral initiation is one method of feedback communication.

- The effectiveness of a referral system is determined by the individuals being referred, so it is essential to find out if a client is satisfied with the service received and whether her or his need was met. One method of getting this information is that the hospital that made the referral will contact the client directly for feedback, if the client agrees. Another way is to carry out periodic surveys at different points (hospital, health centre etc) in the system.

Bed Management

The aim of bed management is to make maximum use of hospital beds, ensuring high bed occupancy, high patient turnover and minimum waiting times for elective admission.

- Methods for ensuring appropriate utilization of bed
  a. Follow hospital A & D protocol2
  b. Reduce inappropriate length of stay
     - Regular ward rounds
     - Make maximum use of administrative service
  c. Bed management information system
     - Bed survey should be done at least 3x a day/3 times/24hrs/

At any time, the liaison should and have the following information:

- ☞ Free beds in the health hospital
- ☞ Number of beds that are due to be evacuated
- ☞ Likely discharges planned during admission
- ☞ Number of beds Occupied in the hospital
- ☞ Number of patients transfer ins and outs
- ☞ Number of reserved beds for elective admissions that day

Whenever the hospital is in acute shortage of beds for emergency admission:

- ☞ Try to find beds in other wards by communicating with ward clinicians
- ☞ Look for likely discharges, if any transfer to waiting place
- ☞ Cancel appointed elective admission patient/s for that day
- ☞ If all the above-mentioned solutions are not applicable, refer to the nearest health hospital after the patient is made stable and bed/service is secured in the accepting health hospital.

Admission and Discharge Process

Effective and coherent admissions and discharge policy for emergency and elective patients are very important for proper utilization of hospital beds. Based on admitting physician's recommendation liaison officer should coordinate beds for admission (Please refer Annex VI: Admission urgency notification card).

Processes on admission:

Emergency admissions processes

Ideally the length of stay should not be greater than 24 hours. Then transfer to ward has to be facilitated for proper inpatient admission if necessary.

If the patient is to be admitted as an inpatient, a clinical member of emergency case team should contact the liaison officers.

As a minimum the following information has to be delivered:

- Patient name and medical record number
- Summary of the clinical history and reason for emergency admission
- Case team to which patient should be admitted like surgical case team, internal medicine case team etc
- Expected date of discharge

When request for admission is made the liaison officer should follow the steps below:

- **Is a bed immediately available in the relevant inpatient case team/ward**
  If yes – admit patient

  The liaison officer should inform the case team leader of the receiving ward that the patient should be transferred to that ward and any necessary administrative tasks carried out with the assistance of runner.
- **Is there any patient in the relevant case team /ward due to be discharge that day?**
  If yes --- confirm that patient will be discharged. Identify and address any factors that are delaying discharge. Consider moving patient to transit lounge (if available) or another waiting area. In this way the bed can be freed and the new patient can be admitted
- **Is a bed available within another case team/ward?**
  If yes --- discuss with director of inpatient service and the responsible physician for the patient where the patient is located, ensure the patient will be properly followed and managed by appropriate case team, and ensure that the patient is transferred to correct case team bed/ward as soon as a bed is available.

Elective Admission Process

Liaison officer has to book elective admission.

- When a patient requires elective admission a clinical member of the relevant case team should send at minimum the following information:
  - ☞ Patient name, phone number and medical record umber
  - ☞ Summary of the clinical history and reason for admission.
  - ☞ Case team to which patient should be admitted like surgical case team, internal medicine case team etc.
  - ☞ Urgency of admission (set criteria related to: pathology of the disease, socio-economic status of the patient, and distance of the patient'sresidence).
- The liaison officer should book the admission date and give an appointment card to the Patient and patient number, and take contact information of patient and/or care giver. The liaison officer should also give his/her or office contact address to the patient so that the patient can phone and get information about his/her admission schedule.
- On the day of admission, the patient should report to the liaison officer and from there he/she will be assisted to make any necessary payment or registration and will be directed to the relevant inpatient case team/ward.
- On a daily basis, the liaison officer should inform each inpatient case team of planned admissions for the following day to ensure that the required service is available and allow the case team to make all necessary preparation for the admission.
- In case admission schedule or treatment is changed the liaison officer should inform the patient and family.
- **The following key requirements have been identified to facilitate effective elective admission practices:**
  - ☞ All patients should have a treatment plan within 24 hours of admission.
  - ☞ Centralized waiting list management.
  - ☞ Agreement on the parameters for scheduling operation theatre lists with the OR team.
- **Effective management of the admission process requires knowledge of:**
  - ☞ The total number of beds
  - ☞ The number of occupied beds at the evening census (bed occupancy)
  - ☞ The number of beds that are to be evacuated that day

Canceling Appointments for Admission:

Issues to be considered while cancelling appointments

- Is an elective admission to be cancelled to make bed available for another patient?
- As far as possible, planned admissions should not be cancelled.
- However, depending on the priority, it may be necessary to do so.

Factors to be considered are:

- ✓ The clinical urgency of both the planned admission and the emergency patient requiring admission.
- ✓ The time on waiting list, distance travelled and other pertinent social circumstances of the elective case.
- ✓ The availability of a bed in other hospital for the emergency patient requiring admission.

If a bed can be made available by any of the steps above then the patient should be admitted. If a bed is not available or if the required service is not available at the hospital then the patient should be referred to another hospital and this has to be accomplished after confirmation of availably of beds in another hospital.

Discharge plan during admission

A physician who should complete a discharge summary for the patient should make the decision for discharge. A copy of the discharge summary containing medical history should be given to the patient and a second copy filed in the Medical Record. If a patient was referred from another hospital the discharging physician should also complete the feedback section of the Referral Form.

The processes required for effective discharge planning provide that:

- ✓ There should be an organization led commitment to manage all hospital beds.
- ✓ Resources such as a discharge coordinator should be available to ensure delays are minimized and extensive patient and family involvement in decision-making processes.
- ✓ Referrals to physiotherapy, occupational therapy, and psychosocial support should be identified as early as possible to access aids and appliances as appropriate.
- ✓ Discharge documentation should be audited to ensure compliance with hospital protocols.
- ✓ Analysis of trends and data should be undertaken by the Liaison Officer and communicated to hospital senior management.
- ✓ Multidisciplinary teamwork is the key to success with discharge planning. A nominated

member of the multidisciplinary case team should coordinate a patient‟s discharge plan.

- ✓ Patients and their caregivers should be partners in the discharge planning process.
- ✓ Discharge planning should be continually updated and improved.
- ✓ Liaison officer should identify and resolve bed management problems with the support of the hospital Senior Management Team.
- ✓ There should be early involvement of Pharmacy to increase compliance with medication.

- Patients (or parents, caregivers, surrogate, or guardians) should co-sign the patient's discharge letter ensuring that the discharge instructions have been clearly explained to them.
  - ☞ An expected date of discharge should be set within 24 hours of admission/stay or in many cases before admission/stay for elective patients and communicated to the patient and all staff in contact with the patient.
  - ☞ The expected date of discharge should be proactively managed against the treatment plan (usually by ward staff) on a daily basis and changes communicated to the patient
  - ☞ A senior clinical staff member should schedule Ward rounds in a way that allows at least daily review of all patients.

Inpatient case teams can make significant improvements by:

- ☞ Identifying anticipated length of stay and expected date of discharge on admission/stay;
- ☞ Using a Discharge Predictor as a core tool for effective bed management;
- ☞ Providing an updated list of expected discharges on a shift basis;
- ☞ Discharging patients in the morning on the day of discharge, and;
- ☞ Discharging patients over the weekend and holidays.

Key Steps in Timely Discharge

- ✓ Expected date of discharge is identified early as part of patient's assessment within 24 hours of admission/stay (or in pre-assessment for elective patients). It is based on the anticipated time needed for tests and interventions to be carried out and for the patient to be clinically stable and fit for discharge.
- ✓ In parallel, all the necessary arrangements are put in place to optimize the (simple) discharge including Discharge Summary, outpatient appointment, hospital sick leave completed, any medicines to be taken away, and patient transport arrangements confirmed.
- ✓ Review of planned/actual discharge date. Did it go according to plan? Complete audit on a regular basis.

Liaison and Patient Communication

A liaison should try to calm down an anxious patients and families and should inform the patient about the following issues.

- The reason and importance of referral
- How to get receiving hospital (location and transportation)
- Whom to see and what likely to happen
- An estimate of cost of the service
- After finishing the service to return back with the feedback paper.

Organization and Resource for liaison service

- The liaison and referral service should be available 24 hours a day, 7 days a week, and 365days a year.
- Based on the capacity/patient load of the hospital, a hospital can set the number of liaison officers.
- If the case load is low, the hospital can orient some of the emergency department staffs on referral coordination and may use this staffs on duty hours.
- The liaison office has to be established as a unit. It must be located in an area which is easily accessible, and clearly visible to incoming patients.
- The office should have access to telephone, manual and computerized registration systems and if possible, Internet service, fax machine and photocopier.
- The qualification of a liaison officer should be Diploma or above preferably in health science and can also be social science or information science professional.

Documentation and Reporting

The liaison has a responsibility to document its activities including referrals and A&D process in order to:

- Monitor referral volume so that, it allows the hospital to better plan
- Identify the Initiating hospital so that it can eases the reimbursement of service fee for fee waiver patients based on health care financing procedure.
- To appropriately manage the hospital bed
- Manage appointments for elective patients
- Follow timely discharge
- Monitor and evaluate the performance of referral system at hospital and health center level to continuously improve the quality of referral service.
- Strengthen accountability of referral care
- Be able to conduct researches
- To use on national, regional and catchment level review meeting with view to improvement

What to document?

- Liaisons should document referral in and out register.
- **For referral in** documentation a register should be in place at **Triage, ER and labor ward** in addition to **liaison office**.
- The staffs in the above case teams have the responsibility to record every referral in on the register.
- The liaison officer has the responsibility to follow the documentation and **aggregates all** received referrals and report t on **a monthly basis**.
  - Every admitted patient with their ward and EDD (expected date of discharge)
  - Bed management details of bed information should be documented (**please see the annex for bed management capturing format)**
  - For **all appointed patients** their **appointment date**, the **appointed department**, **appointed physician** and **details of the patient address** should be documented

Reporting

- The liaison officer should analyze and report referral and A&D reports on regular bases (monthly, quarterly, biannually and annually to the hospital SMT)

Monitoring and Evaluation of the Referral System

III. Hospital level.

- Incorporate liaison service on regular performance review.
- Data based monitoring and evaluation (using KPI and other indicators)
- Conduct internal supervision on liaison service
- HSMT (hospital senior management) consider recommendations of liaison service, referral service and bed management address issues and share development and issues with RHB at regional review meetings.
- Review catchment performance of referral

iv. Health center.

- Conduct internal supervision on liaison service
- Data based monitoring and evaluation on referral system.
- Monitor the referral system performance with catchment Health post and catchment leading hospital.

Hospital Based liaison service M & E Technics

A&D monitoring

- A Hospital can monitor A&D process using two major techniques:-
    - A. Periodic audit of A&D process and
    - B. Using Patient flow indicators of KPI

A. Periodic A&D Audit

The audit of the admission and discharge protocols is a key process in ensuring that staff are aware of them, and that there are implements and adhered to every hospital should therefore carry out a periodic audit of the A&D process

Senior management may use two approaches in audit

1) A systematic sample approach
2) A target approach where there is identified or suspected

issue This framework covers the systematic sample approach

Auditing checklist

1. Sample Approach

- ✓ The audit should be conducted using a sample of cases.
- ✓ The cases should be the same for both the admission and discharge elements of the protocol
- ✓ The sample should be made up of both **emergency** and **elective cases** and should cover all of the major clinical areas. **Medical, Surgical, Obs & Gyne, Pediatrics**
- ✓ The split between the number of emergency cases and elective cases in the sample should be in their proportion the **total number admission in the quarter** (**3month period**) proceeding the month in which audit is being conducted.

For example

There are100 cases in the period of which 20 are elective and 80 are emergency, the sample would be made up of 80% emergency cases and 20% elective cases

- The responsibility for conducting the audit should be clearly assigned, perhaps to the Quality Team.
- Each person taking part in the audit should be oriented on the purpose, process and tools of the audit.

Key documents and considerations for audit include:

1) The patient notes
2) Waiting list
3) That elective admissions are in accordance with the clinical priority stated in the noted by the doctor
4) That there is general consistency in the assignment of clinical priority for the same conditions
5) Using the admission checklist look for evidence of compliance with the checklist. Review discharge information in the liaison office ascertain whether or not discharge is occurring seven days
6) Using the discharge checklist, look for evidence of compliance with the checklist. Note any non-compliance

   The sample A&D checklist and admission urgency notification card is attached on the annex.

2. Indicator based Monitoring

Following, note the trends and obtain explanations for significance increases or decreases of the following indicators the hospitals can carry out a **crude monitoring on A&D process**

a. KPI 1.11 - ER length of stay >24hours
b. KPI 1.2 – Bed occupancy rate
c. KPI 1.3 – average length of stay
d. KPI 1.18 - delay for elective surgery admission

Referral Monitoring

Hospital can use the following data to regular monitor their liaison and referral service Data Based monitoring can be applied to follow the performance of referral service which can be utilized during different performance review meeting. Facilities can also monitor their referral care performance by auditing for particular cases of referral.

Indicator	Numerator	Denominator	Why Track This?	Data Source
1. Referral rate from referring service	*# clients referred out from referring service*	*Total # clients seen*	Indicates if all appropriate clients being Referred. Appropriate benchmarks	• Register at referring service
2. Referral uptake rate	*#clients who complete Referral (get service at receiving end)*	*# clients referred*	A barometer of referral success (if low, should trigger further investigation into	• Compare registers at receiving and
3. Proportion of feedback received from	***Feedbacks received for referred case***	***Total number of referrals***	**Used to monitor the feedback communication among service providers**	**Referral register**
4. Median delay in Completing Emergency referral	*Median # minutes from referral to completion*	*(not applicable)*	• In cases where timeliness of referral is essential (e.g., urgent medical Problems), this is most useful. • Need referral date and time to be	• Register at receiving service • Tracking slips Using Survey Method
			distribution unlikely, making mean Less useful.	
5. Client satisfaction with referral	*# clients who state they were satisfied with the referral*	*# clients referred*	• This is the one outcome of referral that is most easily tracked, rather than being deferred to an evaluation	• Register at referring service • Periodic survey of consecutive
Proportion of emergency referral out cases with ambulance service	*Number of emergency referral outs with ambulance service (Ambulance from health hospital or Woreda or command center)*	*Total number of emergency referrals*	To measure access of Ambulance service for ER referrals	Referral out register

Annex 1. A Sample referral and feedback format1

Name of hospital:	**Referral Form**					
Referred by:	Name:		Position:			
Initiating Hospital Name Telephone Address:				Date of referral: Time at Referral :		
Telephone arrangements made:	YES	NO				
Referred to Hospital Name and Address:						
Client Name						
MR Number				Age:	Sex:	M F
Client address						
Clinical history and Physical examination						
Diagnosis						
Treatment given						
Reason for referral						

Investigation and other accompanying documents		
Print name and sign	Name:	Signature:
Note to receiving hospital: On completion of client management please fill in and detach the referral back slip below and send with patient or send by fax or mail.		

----------□----------receiving hospital - tear off when making **back referral**---------
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Back referral from Hospital Name		Tel No.	Fax No.		
To Initiating Hospital: *(enter name and address)*					
Client Name					
MR Number		Age:	Sex:	M	F
Client address					
Patient history					
Special investigations and findings					
Diagnosis					
Treatment / operation					
Medication prescribed at discharge					
Any need for Medication and ,follow up					
Refer back to:		on date:			

Print name, sign & date	Name:	Signature:	Date:
Reply from (person completing form)	Name:		Date:
	Position:	Specialty:	

Annex 2. A sample referral out and referral in register

Register of Referrals OUT												
Date referral made	**Client Name**	**Sex(F/M)**	**MRN**	**Referred to** ***(name of hospital / specialty)***	***Diagnosis***	**Referred for**	**Ambulance arranged (for Emergency)** **(Yes/No/NA)**	**Advanced Call to receiving facilitated was made** **(Yes/No)**	**Date Back referral / feedback receive**	Follow-up required YES / NO	Follow-up completed YES / NO	**Appropriate referral YES / NO**

Register of Referrals IN									
Date referral received	**Client Name**	**Sex(M / F)**	**MRN**	**Referred from** *(name of hospital / specialty)*	**Diagnosis**	**Reason for referral**	**Appropriate referral YES / NO**	**Summary of treatment provided**	**Date Back referral / feedback sent**

Annex3.Bed Management Information Capturing Format

Ward Name	1.Total Bed	2.Occupied bed			3.Possible Discharge			4.Booked elective admissions	5.Transfers	Free Beds 1-(2-3+4) ± 5		
		M	A.F	N	M	A.F	N			M	A.F	N
	32	20										

Key for Table

M ----------Morning

A.F---------After noon

N ----------Night

Annex 4 .Sample Admission Urgency Notification Card

Date ----------

Name of the department issuing admission ----------

Name of the patient ----------

Card number ----------

Urgency of the admission

Emergency (immediate admission)---------- ☐

Non emergency but priority (admission within two weeks)---------- ☐

Not emergency(admission in two weeks or more) ---------- ☐

Name and signature of the physician approving admission

Name and signature of the Liaison officer accepted admission

Date of patient appointment for admission ----------

References

1. Ethiopian Hospital Reform Implementation Guideline (EHRIG)
2. Draft Reference Manual on Patient Referral System Network
3. Guideline for implementation of a patient referral system
4. The national admission and discharge protocol for hospitals