



SIGN Publication
Number **31**

Scottish
Intercollegiate
Guidelines
Network

Report on a Recommended Referral Document

November 1998



Referral Document Working Group

Dr Stuart Watson (<i>Chairman</i>)	<i>Lecturer in Public Health Medicine, University of Aberdeen</i>
Dr Graham Douglas	<i>Consultant Physician, Aberdeen Royal Infirmary</i>
Dr Elizabeth Duncan	<i>General Practitioner, Lanarkshire</i>
Dr Alasdair Dutton	<i>General Practitioner, Perth</i>
Mr John Hamley	<i>Assistant Clinical Director, Ninewells Hospital and Medical School, Dundee</i>
Dr Alan Hyslop	<i>Strategy Manager, Information Management and Technology Division, Scottish Office Department of Health</i>
Dr Lind MacDonald	<i>Radiologist, Eastern General Hospital, Edinburgh</i>
Rose O'Hara	<i>Clinical Nurse Manager, Department of Orthopaedic Surgery, Royal Infirmary of Edinburgh</i>
Mr Ian Ritchie	<i>Orthopaedic Surgeon, Stirling Royal Infirmary</i>
Dr Christine Rodger	<i>Consultant Physician, Monklands Hospital, Airdrie</i>
Ms Audrey Stacey	<i>Information Consultant, Information and Statistics Division, Common Services Agency</i>
Miss Joyce Thompson	<i>Nutrition and Dietetic Manager, Stracathro Hospital, Brechin</i>
Dr Keith Wycliffe-Jones	<i>General Practitioner, Inverness</i>

Specialist Reviewers

Dr Lawrence Bidwell	<i>General Practitioner, Dumbarton</i>
Dr Clare Campbell	<i>General Practitioner, Broxburn, West Lothian</i>
Dr Philip Cotton	<i>General Practitioner, Glasgow</i>
Dr Robert Heading	<i>Consultant Physician, Royal Infirmary of Edinburgh</i>
Dr Chris Johnstone	<i>General Practitioner, Paisley</i>
Professor Roland Jung	<i>Consultant Physician, Ninewells Hospital and Medical School, Dundee</i>
Dr Allan Merry	<i>General Practitioner, Ardrossan</i>
Professor Lewis Ritchie	<i>Professor of General Practice, University of Aberdeen</i>
Dr Diana Russell	<i>General Practitioner, Dundee</i>
Professor Nigel Stott	<i>Professor of General Practice, University of Wales College of Medicine</i>
Dr Charles Swainson	<i>Medical Director, Royal Infirmary of Edinburgh</i>

SIGN Editorial Board

Dr Doreen Campbell	<i>CRAG Secretariat, Scottish Office</i>
Dr Patricia Donald	<i>Royal College of General Practitioners</i>
Dr Jeremy Grimshaw	<i>Health Services Research Unit, University of Aberdeen</i>
Mr Douglas Harper	<i>Royal College of Surgeons of Edinburgh</i>
Dr Grahame Howard	<i>Royal College of Radiologists</i>
Dr Peter Semple	<i>Royal College of Physicians & Surgeons of Glasgow</i>

SIGN Secretariat

Professor James Petrie	<i>Chairman of SIGN, Co-editor</i>
Lesley Forsyth	<i>Conferences Coordinator</i>
Robin Harbour	<i>Information Officer</i>
Juliet Harlen	<i>Head of SIGN Secretariat, Co-editor</i>
Paula McDonald	<i>Development Groups Coordinator</i>
Joseph Maxwell	<i>Publications and Communications Coordinator</i>
Judith Proudfoot	<i>Assistant to Head of SIGN Secretariat</i>

Contents

1	Introduction		
1.1	Background	_____	1
1.2	Aims of the referral document	_____	1
1.3	The need for a recommended referral document	_____	1
1.4	Mode of communication	_____	2
2	Development of the referral document		
2.1	Literature review	_____	3
2.2	National consensus conference	_____	3
2.3	Formulating recommendations	_____	3
3	Implementation of the referral document		
3.1	Referral document template	_____	4
3.2	Information technology and electronic communication	_____	4
3.3	Electronic referral document	_____	5
3.4	Opportunities for audit	_____	5
4	Recommended referral document	_____	6
5	References	_____	11

1 Introduction

1.1 BACKGROUND

Referral letters of high quality are an essential part of good clinical care.

The general practitioner is the gatekeeper to secondary care and is charged with the decision when to refer a patient and to whom the referral should be made. Therefore, the general practitioner has an explicit role in the efficient delivery of health care within the National Health Service. Following the decision to refer a patient to a professional working in the secondary care environment, there is usually a written communication sent from primary care.

1.2 AIMS OF THE REFERRAL DOCUMENT

Referral letters are a flexible means of transferring information between health professionals, as they can be adapted in form and content to cover both straightforward and complex clinical cases. In addition to this function, it is acknowledged that the referral letter can be used as a tool for clinical audit.

Good quality referral letters are an essential part of good clinical care and act as the interface between health care professionals in primary and secondary care. As such they have a number of functions: the referral letter provides patient information, which will include demographic details, as well as clinical information relating to the reason for the referral decision. In addition, the referring professional may choose to include information which would be otherwise unavailable to the receiving health professional. The referral letter is also used by medical records, appointments and clinic staff and necessarily includes a significant amount of administrative information.

1.3 THE NEED FOR A RECOMMENDED REFERRAL DOCUMENT

The referral letter is usually written following a consultation between the patient and the general practitioner. This usually takes place in the general practice surgery but the letter may have to be written in the emergency setting, such as in a patient's home when urgent admission is required. In either case, adequate clinical information is essential to allow the secondary care professional to assess clinical need and urgency. In the referral process, letters are the standard—and typically the sole—method of communicating information between general practitioners and hospital specialists. These letters have been the subject of comment for many years: written communication between primary care practitioners and secondary care specialists is often haphazard and lacking consistency of content. While this may have improved over the last 10 years, evidence remains to suggest that the quality of written communication could be improved.¹⁻¹⁴

Following publication of the Scottish Intercollegiate Guidelines Network (SIGN) recommended minimum dataset for the immediate discharge document,¹⁵ SIGN established a multidisciplinary working group to review the published evidence and examples of good practice and make recommendations on a minimum essential dataset for communication from primary to secondary care. Although, by the nature of the subject, the majority of the evidence comes from non-experimental descriptive studies and expert opinion, the recommendations in this report should be regarded as being based on the best available evidence to date (see section 2).

The recommended referral document is designed primarily for general practitioner referrals, but it is intended to be suitable, with appropriate modification, for use by professions allied to medicine in any setting. The working group considered the information necessary for both routine/elective referrals and referrals made in an emergency or acute situation, and has made recommendations accordingly.

1.4 MODE OF COMMUNICATION

A typed referral letter sent by conventional postal services or an internal hospital mailing system is the traditional method of conveying information from the referring doctor to the receiving doctor. It may be that, with emerging technologies, other forms of communication will become acceptable, e.g. fax and electronic mail. Using electronic communication, there may be no requirement for information inputted by primary care staff to be re-inputted by staff in the secondary care setting. This is the principle of single data entry.

The SIGN working group has tried to take account of new methods of transferring information such as the NHSnet, or other electronic mailing systems. As a supporting initiative, the Information Management & Technology division of the NHS Management Executive have commissioned the development of an electronic version of the recommended referral document, designed to be compatible with most standard GP computer systems (see *section 3*).

For the purposes of this report, the 'referral letter' should be seen as equivalent to the 'referral document' or other method of transferring information between professionals. Irrespective of the method of transferring information, the information content will remain the same.

2 Development of the referral document

2.1 LITERATURE REVIEW

The SIGN working group undertook a detailed review of the literature relating to the referral document. A number of computerised bibliographic databases were searched, including MedLine, Embase, Applied Social Sciences, Current Contents, DHSS-DATA, Health Planning and Administration, and the Social Science Citation Index. Searches using the 'MeSH' subject headings of 'Referral and Consultation' were conducted, with search strategies similar to the following:

1. FAMILY PRACTITIONER\$ or FAMILY PRACTICE or GENERAL PRACTITIONER\$ or GENERAL PRACTICE or GP
2. REFERRAL or LETTER\$ or CORRESPONDENCE or COMMUNICATION\$
3. 1 and 2.

Discussion with colleagues in Scotland and in other parts of the UK revealed a small number of additional references, all of which were collected and included in the review.

This search strategy revealed around one hundred articles relating to referral communication. All abstracts were scrutinised and around 60 papers were found to be of direct relevance and so appraised by members of the working group, using a structured framework for appraisal, data abstraction and subsequent synthesis of the information. *(For further details, please contact the SIGN Secretariat.)*

By the nature of the subject, no evidence exists from randomised controlled trials as to whether improvements in referral communication change patient outcomes. Therefore the majority of the evidence comes from non-experimental descriptive studies and consensus methods in which referral letters are judged by a panel of experts and scored accordingly.

2.2 NATIONAL CONSENSUS CONFERENCE

In order to compensate for the absence of high quality published evidence relating to the referral document, the SIGN working group decided to hold a national consensus conference to allow health care professionals from across Scotland to discuss the subject in detail. Delegates were asked to complete a questionnaire before and after attending the conference. The results provided the working group with further evidence of what should be contained within the referral letter and how letters may be used in the future.

2.3 FORMULATING RECOMMENDATIONS

From the literature review and analysis of the results of the national consensus conference, the working group was able to derive recommendations on essential information for inclusion in referral letters. However, the working group did not consider it possible to specify the grade of recommendation for individual pieces of information, as the referral letter should be regarded as one entity, requiring all elements to be present, for effective information transfer and seamless patient care.

The recommendations are presented in section 4 as a suggested template for referral communication. Where a piece of information is described as 'essential' it should appear in both elective (routine) and emergency referral letters. Other pieces of information should always appear in elective referral letters, but may be omitted in letters relating to emergency referrals.

3 Implementation of the referral document

3.1 REFERRAL DOCUMENT TEMPLATE

The suggested template for referral communication has been produced in liaison with the Information and Statistics Division (ISD) of the Common Services Agency for the NHS in Scotland. National definitions and codes, where available, should be adopted and have been used in the generation of the list of essential pieces of information to be included in referral communication. These definitions are set out in the ISD Definitions and Codes for the NHS in Scotland¹⁶ (*available from Phil McNicol, Definitions and Standards Manager, Information and Statistics Division, Trinity Park House, South Trinity Road, Edinburgh EH5 3SQ*).

While one particular format has been suggested in order to encourage a general uniformity of referral communication across Scotland, it is recognised that local areas and particular disciplines may wish to modify the template according to local circumstances or discipline-specific needs.

3.2 INFORMATION TECHNOLOGY AND ELECTRONIC COMMUNICATION

Information Technology at several levels can support the implementation of the recommended referral letter. Each level brings further benefit to the speed and accuracy of the referral process. When considering the appropriate level for them, a practice needs to consider what will best suit their methods of working now and in the future. Key questions to be addressed include:

- ***How can we save time and increase accuracy when producing the letters?***

There are various ways of semi-automatically producing the forms/letters. At its simplest this means using a word-processing template with, for example, the practice code preset in the form. A more sophisticated method would be to cause the relevant patient's details to be automatically extracted from the practice system and inserted in the right place in the letter.

Contact your practice's system supplier for advice, preferably through User Groups so that preparatory work need only be done once and shared by all (this is the bonus of a Scotland-wide standard format). This is already underway for the GPASS system.

- ***What's the best way of getting the 'free text' into the letter?***

Options are typing in of handwritten notes or tape dictation followed by audio-typing. The most futuristic – and potentially the most beneficial – is for GPs to use voice dictation computer programs, meaning that the spoken word is automatically translated into typing which appears on the screen. The technology to do this has been disappointing and expensive until recently, but trials are underway of GPs using more modern and cheap programs.

- ***How are we going to send the letters?***

Options include 'surface' mail, fax, e-mail, and 'structured' e-mail. Clearly the latter three options reduce delay compared to traditional mail. Faxing is less secure and may have legibility problems. E-mail is becoming the option of choice with the installation of NHSnet connections in practices and Trusts, and this is being developed in several parts of Scotland. Due recognition must be given to establishing secure methods of communication to safeguard patient confidentiality. 'Structured' e-mail refers to a special type of transmission (using electronic data interchange) which allows information from the incoming letter to be extracted and automatically put into waiting slots in the appropriate hospital system. Apart from saving re-typing at the hospital end, this brings considerable clinical benefits, e.g. making past medication details instantly available.

The training of staff in the use and transmission of the referral document is crucial. Technology without proper staff preparation and ongoing support is a waste of time.

3.3 ELECTRONIC REFERRAL DOCUMENT

This report on the recommended referral document is being made available in the traditional paper-based format which will allow practitioners to read, digest and implement it in their own timescale.

In addition, a software package has been commissioned by the NHS Management Executive which semi-automatically produces referral letters using the recommended template. The system can be set up to hold the required practice information and can accept patient data exported from the practice system. A copy of this program will be sent to each general practice in Scotland. Should it fail to arrive within two weeks of the distribution of this report, requests for a copy can be made by telephoning 01360 620944 or writing to SIGN IT!, PO Box 3967, Glasgow, G51 4YA.

3.4 OPPORTUNITIES FOR AUDIT

The SIGN working group is aware that audit activity is an important method of ensuring quality in clinical care. It has been suggested that the referral letter provides a clinical window into the mind of the referring practitioner. If this is the case, one would be able to draw conclusions about standards of general clinical care.^{17, 18} While this may be a tenuous link, audit of referral work will give an indication of how well general practitioners and other primary care professionals communicate with colleagues in secondary care.

The suggested template, irrespective of the actual format or mode of transmission, gives a valid 'gold standard' for the minimum essential information which should be included in referral letters. Thus, audit of referral letters against this template will give an indication of the quality of referral communication between primary and secondary care. The SIGN working group recommends that this would be a suitable way to ensure quality in referral communication.

4 Recommended referral document

The suggested template for referral communication is shown on the facing page and overleaf. This is followed by an annotated version, giving additional information on the fields for inclusion in the referral document.

Essential information fields which should be completed in all referrals, including those made in an emergency situation if possible, are marked in **red type**. Other fields include desirable information which may be omitted for emergency referrals, but should be completed in other circumstances if at all possible.

Ambulance transport required?

Yes No

REFERRAL LETTER

— MEDICAL IN CONFIDENCE —

REFERRAL TO

	<p>— Consultant / receiving practitioner and/or specialty clinic</p>										
	<p>— Hospital and Hospital address</p>										
	<p style="text-align: right;">Hospital unit no.</p> <table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 10%; height: 15px;"></td> <td style="width: 10%;"></td> <td style="width: 10%;"></td> <td style="width: 10%;"></td> <td style="width: 10%;"></td> <td style="width: 10%;"></td> <td style="width: 10%;"></td> <td style="width: 10%;"></td> <td style="width: 10%;"></td> <td style="width: 10%;"></td> </tr> </table>										
	<p style="text-align: right;">Email address</p> <table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 100%; height: 15px;"></td> </tr> </table>										
	<p>— Postcode</p> <table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 10%; height: 15px;"></td> <td style="width: 10%;"></td> <td style="width: 10%;"></td> <td style="width: 10%;"></td> <td style="width: 10%;"></td> <td style="width: 10%;"></td> <td style="width: 10%;"></td> <td style="width: 10%;"></td> <td style="width: 10%;"></td> <td style="width: 10%;"></td> </tr> </table>										

Urgency of referral *(give reason if other than routine)*

Urgent Soon Routine

PATIENT DETAILS

<p>Surname <input style="width: 90%;" type="text"/></p> <p>Forename(s) <input style="width: 90%;" type="text"/></p> <p>Previous surname <input style="width: 90%;" type="text"/></p> <p>Title Mr Mrs Miss Ms Other</p> <p style="padding-left: 20px;"> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input style="width: 40px;" type="text"/> </p> <p>Sex M <input type="checkbox"/> F <input type="checkbox"/></p> <p>Date of birth <input style="width: 20px;" type="text"/> <input style="width: 20px;" type="text"/> <input style="width: 20px;" type="text"/> <input style="width: 20px;" type="text"/> <input style="width: 20px;" type="text"/> <input style="width: 20px;" type="text"/> <input style="width: 20px;" type="text"/> <input style="width: 20px;" type="text"/> <input style="width: 20px;" type="text"/> <input style="width: 20px;" type="text"/></p> <p>CHI no. <input style="width: 20px;" type="text"/> <input style="width: 20px;" type="text"/> <input style="width: 20px;" type="text"/> <input style="width: 20px;" type="text"/> <input style="width: 20px;" type="text"/> <input style="width: 20px;" type="text"/> <input style="width: 20px;" type="text"/> <input style="width: 20px;" type="text"/> <input style="width: 20px;" type="text"/> <input style="width: 20px;" type="text"/></p>	<p>Patient's address</p> <div style="border: 1px solid black; height: 100px; width: 95%;"></div> <p style="text-align: right;">Postcode <input style="width: 100px;" type="text"/></p> <p style="text-align: right;">Telephone no. <input style="width: 100px;" type="text"/></p>
---	--

REGISTERED GP DETAILS

<p>Name <input style="width: 90%;" type="text"/></p> <p>Practice code <input style="width: 100px;" type="text"/></p> <p>GP identifier <input style="width: 100px;" type="text"/></p> <p>Email address <input style="width: 90%;" type="text"/></p> <p>Telephone no. <input style="width: 90%;" type="text"/></p> <p>Fax no. <input style="width: 90%;" type="text"/></p>	<p>Practice address</p> <div style="border: 1px solid black; height: 100px; width: 95%;"></div> <p style="text-align: right;">Postcode <input style="width: 100px;" type="text"/></p>
--	--

REFERRING PRACTITIONER DETAILS *(if different from above)*

<p>Name of referring practitioner or agency <input style="width: 90%;" type="text"/></p> <p>Telephone no. <input style="width: 90%;" type="text"/></p> <p>Fax no. <input style="width: 90%;" type="text"/></p>	<p>Address of referring practitioner or agency</p> <div style="border: 1px solid black; height: 100px; width: 95%;"></div> <p style="text-align: right;">Postcode <input style="width: 100px;" type="text"/></p>
---	---

CLINICAL INFORMATION

History of presenting complaint / examination findings / investigation results

Reason for referral (including expectation of referral outcome)

Past medical history (computer generated from problem lists, where possible)

Current and recent medication (computer generated and free text)

Clinical warnings (e.g. allergies, blood-borne, viruses)

Smoking status

Alcohol consumption

No. per day

Units per week

Additional relevant information (including patient's issues, social circumstances, and special needs)

Signature of referring doctor (or other professional)

Date

Essential fields are coloured **red**. Other fields may be omitted in an emergency situation but should be completed in other circumstances if at all possible.

Consultant/receiving practitioner: The name of the person to whom the referral is being made and /or **Specialty clinic/ward:** the clinic to which the patient is being referred.

Surname: The last name currently used by the patient
Forename(s): The forename(s) currently used by the patient, in the correct order

Previous surname: Any previous surname used by the patient, such as maiden name

Title: The title used by the patient

Sex: male or female gender of patient

Date of birth: Date of birth of patient

CHI no: The Community Health Index Number of the patient. This number will uniquely identify the patient within the NHS in Scotland and should be validated by electronic or manual reference to primary care administration (health board / common services agency).

Name: The name of the general practitioner with whom the patient is registered

Practice code: The recognised general practice code

GP identifier: The general practitioner's health board prescribing number

Telephone/fax/e-mail: The telephone/fax/e-mail address of the registered general practitioner.

Name of referring practitioner or agency: The name of the agency making the referral e.g. out-of-hours co-operative or deputising service/locum service/PAM/other GP

Telephone/fax: The telephone/fax number of the referring practitioner.

Ambulance transport required?
 Yes No

Inclusion of this field will depend on locally agreed arrangements for organisation of ambulance transport.

REFERRAL TO

Consultant / receiving practitioner and/or specialty clinic

Hospital and Hospital address

Hospital unit no.

Postcode

Email address

Urgency of referral (give reason if other than routine)
 Urgent Soon Routine

PATIENT DETAILS

Surname

Forename(s)

Previous surname

Title Mr Mrs Miss Ms Other

Sex M F

Date of birth

CHI no.

Patient's address

Postcode

Telephone no.

REGISTERED GP DETAILS

Name

Practice code

GP identifier

Email address

Telephone no.

Fax no.

Practice address

Postcode

REFERRING PRACTITIONER DETAILS (if different from above)

Name of referring practitioner or agency

Telephone no.

Fax no.

Address of referring practitioner or agency

Postcode

Hospital address and postcode: The address and postcode of the hospital to which referral is being made. Each letter or digit of the postcode should be entered in a separate box with a single space left between the two parts of the postcode e.g.

Email address: The electronic mail address of the clinic, hospital or person to whom the referral is being made.

Urgency of referral: The referring practitioner should stipulate how urgently the patient requires to be seen. The definitions of "urgent", "soon" and "routine" will vary between specialty groups, but practitioners should give specific reasons if they believe that the patient requires anything other than a routine appointment.

Patient's address and postcode: The address and postcode to which correspondence should be addressed. This would normally be the patient's usual home address.

Telephone no: The patient's telephone contact number.

Practice address and postcode: The address and postcode of the general practitioner with whom the patient is registered.

Address of referring practitioner or agency: The address and postcode of the agency making the referral.

Essential fields are coloured **red**. Other fields may be omitted in an emergency situation but should be completed in other circumstances if at all possible.

History of presenting complaint/examination findings/investigation results: This section of the letter will convey clinical information. Details of the presenting complaint should be given and where appropriate results of clinical examination given. **If investigations have been performed, e.g. blood tests, copies of laboratory results should be included.**

Depending on the clinical discipline information required will vary, but referring doctors should include sufficient information to give a clear picture of the clinical situation. It may be appropriate to give information about the duration, course and severity of the clinical episode. Sufficient information should be included so that the secondary care doctor can make an informed judgement about the nature of the problem.

Clinical warnings (e.g. allergies, blood-borne viruses): This section of the letter should include information about any factor(s) that puts the patient or health care professional(s) at increased risk. This could include information on known allergies or hypersensitivity, warnings about blood-borne viruses or the potential for such risk. There may be specific information about a patient that is most suitably conveyed in this portion of the letter.

Additional relevant information (including patient's issues, social circumstances and special needs): This section of the letter should contain additional relevant information which has not been included in other parts of the letter. Examples might include clinical or social information specific to the patient being referred; special needs relating to disability; things that the patient cannot or will not divulge to the recipient of the letter but which would be important to ongoing clinical management; and details of the patient's understanding of their condition.

Also, it is important to be explicit about any expectation of the referral process as expressed by the patient and such information could be conveyed in this section of the letter.

CLINICAL INFORMATION

History of presenting complaint / examination findings / investigation results		
Reason for referral (including expectation of referral outcome)		
Past medical history (computer generated from problem lists, where possible)		
Current and recent medication (computer generated and free text)		
Clinical warnings (e.g. allergies, blood-borne, viruses)	Smoking status	Alcohol consumption
 	No. per day	Units per week
 	<input type="text"/>	<input type="text"/>
Additional relevant information (including patient's issues, social circumstances, and special needs)		

Reason for referral (including expectation of referral outcome): The referring doctor should be explicit about why the patient is being referred to secondary care. This will help the receiving doctor understand the nature of, and reasons for, the referral.

This 'reason for referral' should include an indication of the expected referral outcome which, for example, may be 'assessment, investigation and treatment', 'consultation and return to primary care management', 'patient or family request second opinion'.

The referring doctor should be explicit about the type of care being requested such as Inpatient care, Outpatient care, Accident and Emergency care, Day case care, Day patient care, Community care, Direct access care, Domino delivery.

Past medical history (computer generated lists, where possible): This section of the letter should include a comprehensive and relevant summary of the patient's past medical history. It may be possible for this to be computer generated from problem lists already held within the patient's GP notes.

Current and recent medication (computer generated and free text): This section of the letter should include information about the patient's current and recent drug treatment. It may be that this can be generated from a prescribing database within the practice but some acute prescriptions are not held on computer.

The referring doctor may also have knowledge of 'over the counter' preparations being used by the patient which should also be conveyed in this part of the letter.

Smoking status: The smoking status of the patient should be given. This may be expressed as 'the average number of cigarettes smoked on a daily basis'.

If the patient is a former smoker, this information and date of cessation should also be given.

Alcohol consumption: The amount of alcohol consumed on a weekly basis should be given. This may be expressed in 'units per week'.

Signature of referring doctor (or other professional)	Date

Signature and date: The referring doctor should sign and date the referral letter.

5 References

- 1 Coulter A, Noone A, Goldacre M. General practitioners' referrals to specialist outpatient clinics. *BMJ* 1989; 299: 304-8.
- 2 De Alarcon R, Hodson JM. Value of the general practitioner's letter: a further study in medical communication. *BMJ* 1964; 2: 435-8.
- 3 Hodge JA, Jacob A, Ford MJ, Munro JF. Medical clinic referral letters. Do they say what they mean? Do they mean what they say? *Scott Med J* 1992; 37: 179-80.
- 4 Hull FM, Westerman RF. Referral to medical outpatients department at teaching hospitals in Birmingham and Amsterdam. *BMJ* 1986; 293: 311-4.
- 5 Jacobs LG, Pringle MA. Referral letters and replies from orthopaedic departments: opportunities missed. *BMJ* 1990; 301: 470-3.
- 6 Jenkins RM. Quality of general practitioner referrals to outpatient departments: assessment by specialists and a general practitioner. *Br J Gen Pract* 1993; 43: 111-3.
- 7 Kentish R, Jenkins P, Lask B. Study of written communication between general practitioners and departments of child psychiatry. *J R Coll Gen Pract* 1987; 37: 162-3.
- 8 Long A, Atkins JB. Communication between general practitioners and consultants. *BMJ* 1974; 4: 456-9.
- 9 Marinker M, Wilkin D, Metcalfe DH. Referral to hospital: can we do better? *BMJ* 1988; 297: 461-4.
- 10 Newton J, Eccles M, Hutchinson A. Communication between general practitioners and consultants: what should their letters contain? *BMJ* 1992; 304: 821-4.
- 11 Newton J, Hutchinson A, Hayes V, McColl E, Mackee I, Holland C. Do clinicians tell each other enough? An analysis of referral communications in two specialties. *Fam Pract* 1994; 11: 15-20.
- 12 Pullen IM, Yellowless AJ. Is communication improving between general practitioners and psychiatrists? *BMJ* 1985; 290: 31-3.
- 13 Roland M, Porter RW, Matthews JG, Redden JF, Simonds GW, Bewley B. Improving care: a study of orthopaedic outpatient referrals. *BMJ* 1991; 302: 1124-8.
- 14 Westerman RF, Hull FM, Bezemer PD, Gort G. A study of communication between general practitioners and specialists. *Br J Gen Pract* 1990; 40: 445-9.
- 15 Scottish Intercollegiate Guidelines Network (SIGN). Interface between hospital and the community: The Immediate Discharge Document. A minimum data set recommended for use in Scotland. SIGN, Edinburgh 1996.
- 16 Informations and Statistics Division, Scotland. Definitions and codes for the NHS in Scotland: 5th update, February 1997, Edinburgh, Scotland.
- 17 Montalto M. Using referral letters to measure quality and performance in general practice. *J Qual Clin Pract* 1995; 15: 45-50.
- 18 Montalto M. Letters to go: general practitioner's referral letters to an accident and emergency department. *Med J Aust* 1991; 155: 374-7.