

Referral Policy for South African Health Services and Referral Implementation Guidelines



AUGUST 2020



health

Department:
Health
REPUBLIC OF SOUTH AFRICA





FOREWORD

The National Development Plan (2030) requires the health system to provide quality healthcare to all, either free at the point of service, or paid for by public or privately funded insurance. In addition, everyone should have access to an equal standard of basic healthcare regardless of his or her income. South Africa, in striving to provide universal health coverage, is moving to implement National Health Insurance (NHI) by aiming to create equal opportunities to achieve Health for All.

The World Health Organisation (WHO) declared COVID-19 global pandemic on 11th March 2020. *The Referral Policy for South African Health Services*, including the supporting *Referral Implementation Guidelines*, has been developed to address the gaps identified in processing and facilitating timely referral of patients within the healthcare delivery system. This policy strives to restore the dignity of the users of the South African healthcare system, without being punitive to users from impoverished and rural areas. This will serve as one more definitive step towards achieving the vision in the Constitution and Bill of Rights. The lessons from the COVID-19 pandemic, have allowed us to rethink the need for the referral policy that ties the health system together in order for ease of movement of patients between levels and types of facilities. The referral policy will be a tool to facilitate access to the quality patient care, and will be a necessary resource even beyond the COVID-19 pandemic.

It is for this reason that **I approve this policy in order to ease the burden on some parts of the health system and also to make the services more readily accessible to our people**. I, therefore, urge all healthcare managers to use the *Referral Policy for South African Health Services* and *Implementation Guidelines* to improve service delivery and access to appropriate services for the citizens of South Africa.

Dr ZL Mkhize, MP
Minister of Health
August 2020



PREFACE

The healthcare system in South Africa operates in an hierarchical structure, with community-based services at the base of the pyramid and central hospitals at the apex. A functional referral system is essential for the effective operation of such a health system. During COVID-19, the need for the patients to move between various levels of healthcare system to access care became even more paramount. It is clear that beyond beyond this pandemic, the health system must be interlinked through the systematic referral mechanisms which safeguard the users of health services. This referral policy and the implementation guidelines should thus ensure a close relationship between all levels of the health system and should assist in making cost-effective use of hospital and primary care services.

With the implementation of NHI gaining momentum, and new service structures emerging, a working referral system has become a matter of priority. The *Referral Policy for South African Health Services and Implementation Guidelines* sets out the parameters for referral within and across the service delivery platform. It provides guidance on patient referral within the clinical and non-clinical referral pathways, during and beyond COVID-19 pandemic.

A handwritten signature in black ink, appearing to be 'MJ Phaahla', written in a cursive style.

Dr MJ Phaahla, MP

Deputy Minister of Health
August 2020



ACKNOWLEDGEMENT

The health system in South Africa is structured with community-based services at the base of the system and central hospital at the top. The sub-optimal functioning of the referral system is an indication of poor linkages of these levels which undermine the retention and management of the users to care, which in turn hinders the continuum of care for our patients.

COVID-19 has exposed the need for a solid referral system as patients needed to move between facilities and at times between the provinces. The policy and the guidelines have come at an opportune time and will form the basis of the strategies to address COVID-19 and other conditions.

A functional referral system is essential for the effective operation of such a health system at all levels of care, by creating linkages between public healthcare facilities, private sector and community and home-based care (CHBC) providers.

The *Referral Policy for South African Health Services and Implementation Guidelines* was developed in consultation with stakeholders at national, provincial and district Departments of Health.

I would like to acknowledge the contributions of the following team members:

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The performance of the referral system will be monitored and evaluated in a systematic and objective manner to determine its efficiency, effectiveness, impact and sustainability towards achieving the goals of the National Development Plan, during and beyond the COVID-19 pandemic.

Dr SSS Buthelezi

Director-General: Health
August 2020

Referral Policy for South African Health Services



THIS DOCUMENT IS DIVIDED INTO TWO SECTIONS

**Referral Policy for South African
Health Services**

**Section
1**

**Referral Implementation
Guidelines**

**Section
2**

REFERRAL POLICY FOR SOUTH AFRICAN HEALTH SERVICES

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ACRONYMS AND ABBREVIATIONS

A&E	Accident and emergency	M&E	Monitoring and evaluation
AIDS	Acquired Immune Deficiency Syndrome	MDR	Multiple Drug Resistance
ALOS	Average length of stay	MOU	Maternity & Obstetric Unit
ANC	Ante-natal care	MRI	Magnetic resonance imaging
APP	Annual Performance Plan	MVA	Motor vehicle accident
ART	Anti-Retroviral treatment	NDoH	National Department of Health
BOD	Burden of Disease	NDP	National Development Plan
BOR	Bed occupancy rate	NGO	Non-governmental organisation
CBO	Community-based Organisation	NHI	National Health Insurance
CCG	Community care giver	NHLS	National health laboratory services
CCMDD	Centralised Chronic Medicine Dispensing and Distribution	NTSG	National Tertiary Services Grant
CDU	Chronic Dispensing Unit	OPD	Out-patient department
CHC	Community Health Centre	OT	Occupational therapy
CHW	Community Healthcare worker	PHC	Primary Healthcare
CPD	Continued professional development	PMTCT	Prevention of Mother to Child Transmission
DH	District Hospitals	PMPU	Provincial Medicine Procurement Unit
DHIS	District health information system	PNC	Post Natal Care
DHP	District Health Plan	PTC	Pharmaceutical and Therapeutics Committee
DHS	District Health System/Services	RAF	Road Accident Fund
DMT	District Management Team	SAMHS	South African Military Health Services
DSD	Department of Social Development	SANC	South African Nursing Council
EDL	Essential Drug List	SLA	Service Level Agreement
EMS	Emergency Medical Services	SOP	Standard Operating Procedure
GP	General Practitioner	TB	Tuberculosis
HBC	Home based care	THP	Traditional Health Practitioner
HCT	HIV counselling and testing	UHC	Universal Health coverage
HPCSA	Health Professions Council of South Africa	UNAIDS	United Nations on AIDS
HR	Human resources	UPFS	Uniform patient fee schedule
HRP	Hospital revitalisation programme	VCT	Voluntary Counselling and Testing
ICT	Information communications technology	WBPHCOT	Ward based PHC outreach teams
ICU	Intensive care unit	WHA	World Health Assembly
INN	International Non-Proprietary Name	WHO	World Health Organisation
IPC	Infection Prevention and Control	XDR	Extreme Drug Resistance
ISHT	Integrated School Health Teams		

GLOSSARY OF TERMS

Access: Ease with which health services may be obtained and utilised, encompassing geographic, financial and social aspects.

Admission: An act of taking in a patient within a health establishment for observatory, curative or rehabilitative purposes.

Aeromedical services: Refers to an airborne vehicle that is appropriately equipped, designed or adapted solely for the purpose of providing emergency care and conveyance of patients.

Appropriate prescriber: A healthcare professional who may prescribe a medicine based on his/her registration in terms of applicable legislation or authorisation issued in terms of such legislation, the associated scope of practice, qualifications held or courses completed, or the level of care at which the professional is practising.

Appropriate referral: Referral for care to the most suitable level of care in line with the package of services and are referrals which are neither misdirected nor unnecessary and have a completely filled referral form along with necessary clinical details.

Client movement: The process that a client follows in order to seek additional care from an organisation, service or community unit.

Clinic: A fixed structure in which basic health services are provided by nurses and is linked to a community health centre.

Clinical referral pathway Under prescribed medical emergency conditions the healthcare worker may, after clinical assessment of the patient, by-pass the geographical and designated higher level institution and refer the patient to an institution capable of providing the appropriate care, management and/or diagnostic services.

Community-based care: Care that the consumer can access nearest to home, which encourages participation by people, responds to the needs of people and creates responsibilities.

Community Health Centre (CHC): A 24-hour health facility that provides a the comprehensive primary healthcare package of services including a 24 hour emergency unit and maternity and obstetric services.

Consultation: A process a client or health provider uses to seek specialised services.

Counter-referral: A process used to redirect a referred client back to the originating unit for follow-up of the reason for referral.

Directory of services: This is a list of services available at various health establishments. Such a directory can facilitate the search for the most appropriate service provider for a particular referral. Where such a directory is used, it is important that the contact information is kept up-to-date.

Discharge: Release of a client from care or interventions of a health establishment for observatory, curative or rehabilitative purposes.

District hospital: First level non-specialist hospital to which patients from lower levels (clinics, CHCs) may be referred.

Down referral: A process in which healthcare providers at higher level of care who, after managing the clinical condition of the referred patients, may refer the patient back to the referring facility at a lower level facility or to the community-oriented services for continued management, rehabilitation or palliative care.

Emergency Medical Service (EMS): A licensed organisation that is dedicated, staffed and equipped to operate a licensed ambulance, medical rescue vehicle or medical response vehicle in order to offer emergency care.

Emergency referrals: A referral process used for emergency conditions that threaten life, limb or eyesight.

Formulary: A continually updated list of medicines and related information, used in the diagnosis, prophylaxis or treatment of disease and promotion of health, to satisfy the needs of the majority of the population served by a particular health establishment/s.

Health establishment: The whole or part of a public or private institution, facility, building or place, whether for profit or not, that is operated or designed to provide inpatient or outpatient treatment, diagnostic or therapeutic interventions, nursing, rehabilitative, palliative, convalescent, preventative or other health services¹.

¹ South African National Department of Health. National Health Act, 2003 (Act No. 61 of 2003)

Inappropriate referrals: Referrals that incorrectly designate destination or necessity or that lack quality of communication, completed referral forms or accompanying documentation.

Initiating health establishment: An organisation, service or community unit that initiates a referral process by preparing an outward referral to communicate the client's condition and status; an initiating health establishment is also known as a '*referring health establishment*'.

Internal referral: A process in which a healthcare provider within the same institution refers the patient after consultation, to his/her colleague in another section, with a summary of patient's notes, where the consultant will then advise on further management of the patient.

International non-proprietary name (INN): The unique name which is globally recognised and facilitates the identification of medicines (pharmaceutical substances or active pharmaceutical ingredientsⁱⁱ) designated by WHO and thus standardised globally (also known as the generic name).

Lateral referral: Referral of patients between hospitals for the same speciality.

Level of care: Categorisation of health establishments according to the type of healthcare services provided, and aligned with the regulations relating to hospitals published in terms of Section 35 of the National Health Act, 2003 (Act No 61).

Medicine for a chronic condition: Medicine prescribed for an indefinite period of time (e.g. for the treatment of hypertension) or for a defined period longer than one month (e.g. for the treatment of tuberculosis).

Non-urgent or routine referral: A referral process used to seek a second opinion, a higher-level investigation or for routine admissions and client management.

Patient pathway management: is the overarching strategy for identifying and anticipating diverse patient and clinician needs and preferences in order to tailor systems, processes, communications and results. It is the glue that binds together the redesign of services for the benefit of the patient and the delivery of sustainable performanceⁱⁱⁱ.

Pharmaceutical and Therapeutics Committee: A non-statutory, advisory committee constituted in terms of the National Drug Policy (1996) and appointed by the organisation's executive authority in order to ensure the rational, efficient and cost-effective supply and use of medicines.

Planned Patient Transport Services (PPTS): is the systematic transportation of non-emergency patients from one health facility to another within an established referral system.

Receiving health establishment: An organisation, service, or community unit that accepts a referred client from an initiating health establishment.

Referral: Refers to the processes how professionals and institutions communicate and work together to protect, promote and restore the health of an individual. This movement of a patient to another level of care could be internal, upward, downward or lateral for continuity of care.

Referral management: Entails moving from a system that reacts in an ad hoc way to meet increasing needs, to one that is able to plan, direct and optimise services in order to meet the local health needs with the available local, regional and national resources.

Referral management services: Add further value by adding clinical triage to route referrals to the most appropriate healthcare professional and location. The referral management service will either treat immediately, perform first stage diagnostics and/or arrange the most appropriate appointment, either within primary care or at the hospital.

Referral register: A means of maintaining a list of all outward (exit) and inward (entry) referrals for one facility or service provider. Information registered includes client referred, to where, when and why, whether the case is closed or continuing (the returning referral form has been received with any necessary rehabilitation or follow-up), and whether it was an appropriate referral or if there were any issues.

ⁱⁱ World Health Organisation. International non-proprietary names, 2016. <http://www.who.int/medicines/services/inn/en/>

ⁱⁱⁱ Scottish Executive Health Department. *Patient Pathway Management-Referral Facilitation*. 2007. Edinburgh Scottish Executive.

Referral system: Can be defined as a comprehensive institutional framework that connects various entities with delineated (albeit in some cases overlapping) mandates, responsibilities and powers, whose main aim is to protect, promote and restore the health of an individual into a network of cooperation^{iv}.

Self-referral: Any person who presents at the hospital/ higher level of care for examination, medication or treatment without a referral.

Transfer: A management process used to move a client from one facility to another.

Tertiary hospital: A hospital with more specialised services to which referrals from the district and regional levels of care are received.

Upward referral: The process by which healthcare providers at lower levels of the healthcare system seek the assistance of providers, who are better equipped or specially trained, to guide them in managing, or to take over responsibility for, a particular episode of a clinical condition in a patient. The key reasons for deciding to refer either an emergency or a routine case include seeking expert opinion regarding the client; additional or different services for the client; admission and management of the client; use of diagnostic and therapeutic tools.

Urgent referrals: A referral process for conditions that may not threaten life, limb or eyesight but require urgent attention to prevent them from becoming a serious risk to health.

^{iv} United Nations Population Fund. *Strengthening Health System Responses to Gender-based Violence in Eastern Europe and Central Asia – A resource package*. 2014. New York UNFPA and WAVE

INTRODUCTION

The vision of the National Department of Health is “A Long and Healthy Life for All South Africans”. It is envisaged that this will be realised through the prevention of illness and diseases, the promotion of healthy lifestyles and consistently improving the healthcare delivery system by focusing on access, equity, efficiency, quality and sustainability¹.

Guided by Goal 3 of the Sustainable Development Goals (SDG)², and the National Development Plan (NDP) 2030³, the National Department of Health (NDoH) has commenced with the implementation of the National Health Insurance (NHI) as a mechanism to achieve universal health coverage (UHC)⁴. UHC means that all people and communities can use the promotive, preventive, curative, rehabilitative and palliative health services they need, of sufficient quality to be effective, while also ensuring that the use of these services does not expose the user to financial hardship⁵.

Referral refers to the processes by which professionals and institutions communicate and work together to protect, promote and restore the health of an individual⁶. This movement of a patient to another level of care could be internal, upward, downward or lateral for continuity of care.

Thus, a referral system is a part of the comprehensive healthcare service delivery platform to manage the healthcare needs of patients by referring them from an initiating facility to an organisation, service or community unit that can better provide the appropriate level of care required. A well-functioning referral system that allows for continuity of care across different tiers of care is central to the delivery of efficient and effective healthcare towards achieving universal health coverage. The referral system is not confined to formal health facilities but includes linkages to community-based services and other intersectoral services that address the social determinants of health.

For a referral system to work at its best, all levels of the healthcare delivery system need to function optimally. Each facility needs to be clear about its role, responsibilities and limitations; have protocols of care for conditions that are specific for that level of service readily available; and have suitable means of communication and transport to access support from other levels of care.

The referral system in South Africa is faced with a number of challenges such as:

- Lack of an approved referral policy (Draft Referral Policy 2008)
- Inconsistent feedback amongst healthcare providers at all levels of healthcare services
- Inadequate transport and shortage of human resources in general
- Poorly defined linkages between public healthcare facilities, private sectors and community and home based Care (CHBC) providers
- Many patients self-refer directly to hospitals;
 - Appropriately in the case of major trauma as well as complex conditions requiring secondary/tertiary care
 - Inappropriately in the case of minor acute ailments, chronic conditions (e.g., HIV, hypertension, diabetes), and antenatal care (ANC)/child wellness visits better addressed at the primary healthcare (PHC) level.

The lack of an approved referral policy for South Africa has resulted in sub-optimal functioning of the referral system with poor linkages and retention in care, poor continuum of care for patients and the overcrowding of hospitals with inappropriate referrals.

The weaknesses and gaps in the referral system impact on the efficiency and effectiveness of the health system as a whole. Thus this *Referral Policy for South African Health Services and Referral Implementation Guidelines* is a critical tool for strengthening the health system overall.

ORGANISATION OF THE HEALTH SERVICE DELIVERY PLATFORM

The Health Service Delivery Platform is an expression of the organisation of the various parts that make up a well-functioning health system. The purpose of the Health Service Delivery Platform as defined for South Africa is to improve the overall quality of care delivered by the health system moving towards the provision of UHC and the attainment of improvement of health outcomes such that we realise the NDP 2030 goal of *Health for All*.

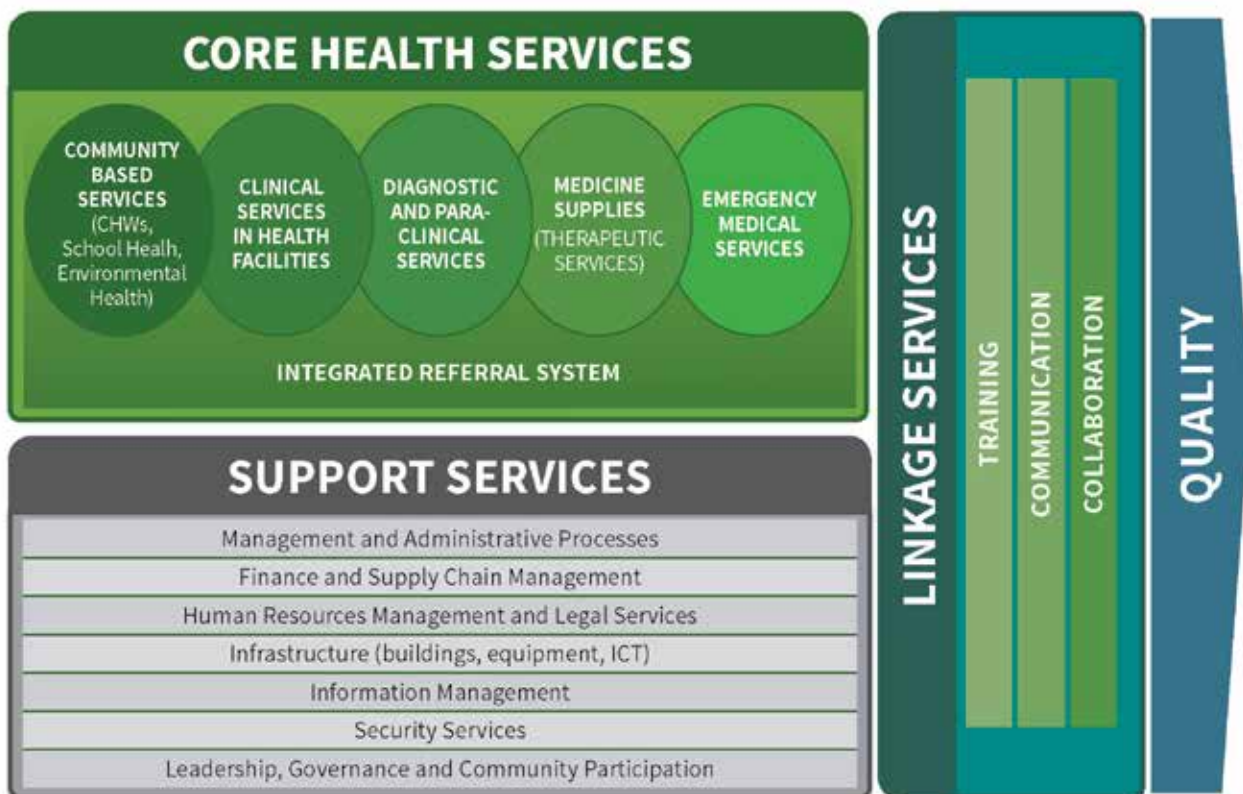


Figure 1: Integrated healthcare service delivery platform

The Health Service Delivery Platform coherently indicates the relationships between the core health services, support services – linked to World Health Organization (WHO) health system building blocks – and linkage services which contribute to the overall functioning and synchronisation of the health services to deliver quality healthcare to users.

CORE HEALTH SERVICES

This refers to the actual health related service components which includes community-based services, designated health facilities consisting of PHC clinics and various levels of hospitals, diagnostic and para-clinical services, therapeutic services and, EMS supported by an integrated referral network (Figure 2).

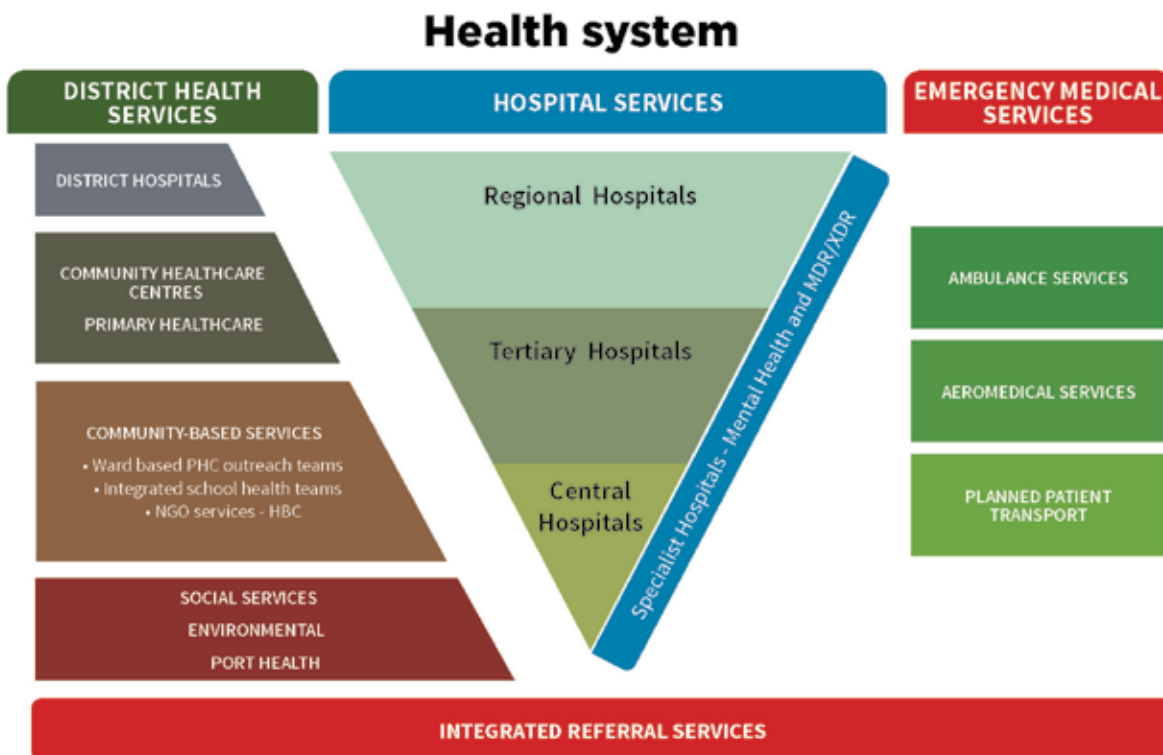


Figure 2: Services across different levels within Health Service Delivery Platform

Community-based services: This consists of services that are delivered within the community setting towards addressing population health issues, responding to the SDGs (sustainable development goals), improving self-management of patients with chronic conditions and identifying neglected persons with disabilities and older persons. ward based outreach PHC teams and Integrated school health teams offer health education, health promotion, screening, prevention of disease, adherence support and de-hospitalised care comprising chronic care, sub-acute care, palliative care, mental healthcare and home-based care at a community level, whilst the district clinical specialist team provide mentoring, supervision, clinical support and outreach services for PHC clinics .

Facility-based clinical services: The PHC clinics and community health centres (CHC) are the first formal institutional point of contact with the health services. Patients may present at the PHC/CHC with any healthcare requirement (whether for promotive, preventive, curative, rehabilitative, palliative or community-based mental health) and will either receive the care they need based on the defined package of services at this level or will be referred to a hospital if more specialised services are necessary (Figure 2).

District hospitals: are the highest level of support within the district health system and thus perform a gatekeeper role in supporting primary healthcare clinics on the one hand and being a gateway to more specialist care (Figure 2). The district hospital provides level 1 (generalist) services to in-patients and outpatients (ideally on referral from a CHC or clinic). In some circumstances, PHC services are rendered at the district hospital where there is no alternative source of this care within a reasonable distance⁸.

Hospital services: A hierarchical relationship exists between the various levels of hospitals as per the defined packages of service. Specialised, regional (Level 2), tertiary (Level 3) and central (level 4) hospitals provide specialist and sub-specialist services (**Regulation R185⁹**) (Table 1). Patients are referred from district hospitals to regional hospitals then to provincial tertiary hospitals and if required, to national referral hospitals and central hospitals depending on the care and intervention required for an individual (Figure 2).

Table 1: Classification of hospitals

DISTRICT HOSPITAL	REGIONAL HOSPITAL	TERTIARY HOSPITAL	CENTRAL HOSPITAL	SPECIALISED HOSPITAL
Serves a defined population within a health district and support primary healthcare	Has between 200 and 800 beds	400 and 800 beds	A maximum of 1200 beds	Has a maximum of 600 beds
Provides a district hospital package of care on a 24 hour basis	Offers services to a defined regional drainage population, limited to provincial boundaries	May provide training for healthcare service providers	Must provide training of healthcare providers; conduct research; and must be attached to a medical school as the main teaching platform	
Have general practitioners and clinical nurse practitioners who provide primary health services	Receives referrals from several district hospitals; provides short-term ventilation in a critical care unit; and where practical, provide training for healthcare service providers	Receives referrals from regional hospitals not limited to provincial boundaries	Receives patients referred to it from more than one province	Receives patients referred to it from other levels of care
May only provide the following specialist services (a) paediatric health services (b) obstetrics and gynaecology (c) internal medicine; (d) general surgery (e) family physician	Provides health services in the fields of internal medicine, paediatrics, obstetrics and gynaecology, and general surgery; and in at least one of the following specialties namely; orthopaedic surgery; psychiatry; anaesthetics; diagnostic radiology; trauma and emergency services	Provides specialist-level services provided by regional hospitals; provides intensive care services under the supervision of a specialist or specialist intensivist	Provides tertiary and central referral services and may provide national referral services	Provides specialised health services like psychiatric services, tuberculosis services, infectious diseases and rehabilitation services

Source: NDoH, Regulation R185

Diagnostic services refer to the branches of medicine comprising the laboratory sciences (microbiology, chemical pathology, pathology, haematology, virology) and radiology and imaging services. These services assist the health professionals in making or confirming a diagnosis for an individual patient.

Para-clinical services include toxicology, pharmacology and forensic pathology that further enhance patient management.

Therapeutic services/medicine supplies relates to the consistent availability and management of medicines, blood and blood products, medical and surgical consumables and assistive devices, including orthotics and prosthetics.

EMS: support the service delivery platform through ambulance services, aeromedical services and planned patient transport services. Ambulance services are required to transfer acutely ill or injured patients between their homes and the nearest health facility as well as between the various levels of facilities (inter-facility transfers). Aeromedical services provide an air ambulance service to transport acutely ill patients from distant referring centres to tertiary or central hospitals. Planned patient transport services are available for all non-emergency patients referred for consultation from one health institution to another that is a significant distance away. This is to ensure that patients reach their referral hospital as per the appointment time. Scarce skills cannot be located at all centres yet patients have to be given the opportunity to benefit from the available specialist skill.

Referral system: is a cross cutting feature of the service delivery platform that underpins the efficient and effective functioning of the health system in an orderly manner¹⁰. This means that patients receive optimal care at the appropriate health facility level through access to appropriate specialist services, without unnecessarily overburdening higher levels of health facilities by inappropriate conditions being seen there. The efficient functioning of the referral system relies on all services being made accessible to correctly screened patients and moved to a higher/lower level of care based on their clinical condition and clearly defined referral pathways.

SUPPORT SERVICES

The support services refer to key administrative and related services that facilitate the core health services to be delivered optimally. The support services align with the Health System Building Blocks of the WHO. Support services refer to key administrative and related services that facilitate the core health services to be delivered optimally. Management and administration processes, finance and supply chain management, human resources management, legal services, infrastructure and health information systems are inter-related corporate support services. Security services, leadership, governance and community participation need to function optimally to ensure core health services are efficient and effective. Each of these blocks need to recognise the interdependence between their roles and responsiveness to core health service requirements and quality of care delivered.

Leadership, governance and community participation are critical constituents to hold management accountable to higher structures but, most importantly, in a social service setting to the communities/public at large.

LINKAGE SERVICES

These are interactive support functions that are essential to ensure both core health services and support services function optimally to achieve the objectives of the healthcare system.

Training or human resource development is a cross cutting support function for both core health services as well as support services. This refers to all levels of training i.e. undergraduate, postgraduate as well as in-service training. Thus, it requires:

- A relationship between academic institutions that produce the various cadres of health and health related professionals as well as other categories of professionals/technicians/artisans that are required for a fully functional health system.
- A knowledge management system to enhance evidence-based healthcare towards improved quality of care and clinical effectiveness.

Communication within and between internal and external stakeholders (communities, private health sector, non-governmental organisations (NGOs), community-based organisations (CBOs), other government agencies) is essential to have an active, informed and participatory citizenry that engages constructively with the health system.

Collaboration is key to the success of the health system in that it relates to both internal and external stakeholders working together. **Internal collaboration** means that within the health system there is a clear understanding of how the various facility levels should work together effectively to deliver seamless services. **External collaboration** refers to the various external stakeholders who impact on the functioning of the health system e.g. communities, private health sector, NGOs, CBOs, other government agencies, academic institutions, training institutions and service providers.

IMPROVED QUALITY OF HEALTH SERVICES AND OUTCOMES

The expected outcome of a well-functioning Health Service Delivery Platform is to improve the quality of services delivered at the different levels of the health system with overarching improvement in health outcomes at a population level. At the healthcare service delivery level this will be manifested by increased coverage and access, better quality of services and improved patient safety. At a population level this will result in improved health, both in terms of level and distribution, better health system responsiveness, resulting in satisfied patients, and improved efficiency of the services.

REFERRAL POLICY FRAMEWORK

ENABLING LEGISLATIVE AND STRATEGIC MANDATES

This Referral Policy Framework is underpinned by key South African legislation and policies and is guided by the values and principles embodied in the World Health Assembly Resolution on “Health for All.” It supports the government’s vision of “a long and healthy life for all South Africans”, and aligns with key strategies and efforts to achieve improved health outcomes.

INTERNATIONAL	
World Health Assembly Resolution 30.43	In 1977 adopted the Resolution on Health for that by the year 2000 all people in all countries shall have a level of health that will permit them to lead a social and economically productive life.
World Health Assembly Resolution 32.30	In 1979, the World Health Assembly adopted the Global Strategy for Health for All by 2000. This strategy calls upon member countries to make a concerted effort to develop health systems. To develop the health systems a supportive referral system is required.
Sustainable Development Goals	Agreed by the 193 member states of the UN, the new agenda, Transforming Our World 2030 Agenda for Sustainable Development, consists of a declaration, 17 SDGs and 169 targets. Ensure healthy lives and promote well-being for all at all ages is goal 3. In addition, the aim is to achieve universal health coverage, provide safe and effective vaccines to all and undertake supporting research.
World Health Assembly Resolution on Universal Health Coverage 64.9	The World Health Assembly urged member nations to aim for affordable universal coverage and access for all citizens on the basis of equity and solidarity, so as to provide an adequate scope of healthcare and services and level of costs covered, as well as comprehensive and affordable preventive services through strengthening of equitable and sustainable financial resource budgeting. To continue, as appropriate, to invest in and strengthen the health delivery systems, in particular primary healthcare and services, and adequate human resources for health and health information systems, in order to ensure that all citizens have equitable access to healthcare and services.
Framework on integrated people-centred health services (IPCHS) - 69th World Health Assembly	The framework presents a compelling vision of a future in which all people have access to health services that are provided in a way that are coordinated around their needs, respects their preferences, and are safe, effective, timely, affordable and of acceptable quality.
NATIONAL LEGISLATIVE MANDATES	
Constitution of the Republic of South Africa, 1996 (Act No. 108)	In terms of the Constitutional provisions, Section 27 details the right to healthcare for the citizens of South Africa: <i>Section 27(1)</i> Everyone has the right to have access to ... healthcare services, including reproductive healthcare. <i>Section 27(2)</i> The State must take reasonable legislative and other measures, within its available resources, to achieve the progressive realisation of each of these rights. <i>Section 27(3)</i> No one may be refused emergency medical treatment. <i>Section 28(1)</i> Every child has the right to ...basic healthcare services... Schedule 4 lists health services as a concurrent national and provincial legislative competence.
National Health Act 61 of 2003	The National Health Act is intended to “unite the various elements of the national health system in a common goal to actively promote and improve the national health system in South Africa.” Chapter 5 provides for the district health system as the operational platform for the national healthcare system.

<p>Refugee Act, 1998 (Act no. 130 of 1998)</p>	<p>According to the provisions in Chapter 5; Section 27 (g), the act prescribes that refugees are entitled to the same basic health services which the inhabitants of the Republic receive from time to time.</p> <p>Refugees and asylum seekers may have access to free primary healthcare services provided that they are not members or beneficiaries of medical aid schemes.</p>
<p>Regulation R 185 Classification of Hospitals</p>	<p>The regulations provide a classification of hospitals based on bed size. Furthermore, a distinction is made between hospitals based on the level of service delivered.</p>
<p>NATIONAL POLICY MANDATES</p>	
<p>National Development Plan 2030</p>	<p>In terms of the plan, by 2030 the health system should provide quality healthcare to all, free at the point of service, or paid for by publicly or privately funded insurance. Everyone should have access to an equal standard of basic healthcare regardless of their income.</p>
<p>National Department of Health Strategic Plan 2015/6-2019/20</p>	<p>The Department's five year strategic goals are to prevent disease and reduce its burden, and promote health; make progress towards universal health coverage through the development of the National Health Insurance scheme, and improve the readiness of health facilities for its implementation; re-engineer primary healthcare by increasing the number of ward-based outreach teams, contract general practitioners and district specialist teams, expand school health services and improve health facility planning by implementing norms and standards.</p>
<p>National Health Insurance Policy 2017</p>	<p>The NHI is expected to transform the financing of healthcare in pursuit of financial risk protection by eliminating fragmentation and ensuring technical and allocative efficiencies in how funds are collected, pooled and used to purchase services, thus creating a unified health system that will move closer to the goal of UHC and SDG 2030.</p> <p>The healthcare system will be reorganised in the areas of strengthening PHC including PHC re-engineering, hospital services and EMS, and improving leadership and governance in the health system through reforms to the management and governance of clinics, districts and hospitals.</p> <p>These services will be delivered through certified and accredited healthcare providers located closest to the covered population. The services to be offered at each level will be defined as a package of service.</p>
<p>National Patient's Right Charter</p>	<p>The National Patients' Rights Charter of South Africa creates a framework for promoting and defending patients' rights. Every patient has the right to amongst others, access to safe healthcare, emergency care in life-threatening situations, exercise choice in healthcare services, be referred for a second opinion.</p>

PURPOSE OF THE POLICY

Section 45 of the Amended National Health Act (No. 61 of 2003) makes provision for a public health establishment that is not capable of providing the necessary treatment or care, to transfer the user concerned to an appropriate public health establishment, which is capable of providing the necessary treatment or care¹¹.

This policy provides all healthcare practitioners involved in the delivery of clinical services and those undertaking the coordination of referral management with a consistent and structured approach to the referral of patients to the appropriate health service. It also aims to ensure timely access to comprehensive healthcare services and to maintain the continuum of care.

OBJECTIVES OF THE POLICY

The specific objectives of the policy are to:

- Ensure that clients receive optimal care at the appropriate level.
- Strengthen coordination and complementation between levels of care, units and institutions in caring for clients.
- Facilitate optimal and cost-effective use of high specialist facilities such as hospitals by patients within and across provincial borders.
- Strengthen peripheral health facilities through feedback that will enhance the skills of the referring doctors by confirming or not confirming diagnoses.
- Enhance utilisation of services at the PHC level by those in need of care.
- Progressively reduce any unnecessary burden on tertiary and specialist hospitals.
- Define governance and other arrangements for referrals between public and private sectors.

SCOPE OF THE POLICY

The policy shall be applicable to all stakeholders in the healthcare delivery system across South Africa, in both the public and private sectors. Implementers of this policy shall be, but are not limited to:

- National government
- Provincial government
- District management
- Hospital/facility management/administration
- Emergency medical services
- Environmental and Port Health
- South African military health services

The following stakeholders are both users and implementers of the Policy

- Public and private healthcare professionals
- Traditional health practitioners
- Community health workers
- NGOs, CBOs, faith-based organisations
- Other government departments
 - Department of Correctional services
 - Department of Justice and Constitutional Development
 - Department of Transport (Road Accident Fund)

- Department of Social Development
- Department of Basic Education
- Department of Labour (Workmen’s Compensation Fund and Occupational Health and Safety Unit)
- South African Police Services
- South African Development Community (SADC) - Intergovernmental arrangements/treaties that exist

GUIDING PRINCIPLES

Constitutional, international, regional, national imperatives and the following key principles guide the development and implementation of the *Referral Policy for South African Health Services*:

- **Accountability:** Healthcare managers have the necessary authority to achieve planned objectives and are accountable for overall performance and results.
- **Accessibility:** Services are directly and permanently accessible without undue barriers of cost, language, culture or geography. Health services are close to the people, with a routine point of entry to the service network at primary care level (not at the specialist or hospital level).
- **Comprehensiveness:** A comprehensive range of health services is provided, appropriate to the needs of the target population, including preventative, curative, palliative and rehabilitative services and health promotion activities.
- **Continuity:** Service delivery is organised to provide an individual with continuity of care across the network of services, health conditions, levels of care and over the life-cycle.
- **Coverage:** Service delivery is designed so that all people in a defined target population are covered, i.e. the sick and the healthy, all income groups and all social groups.
- **Coordination:** The patient’s primary care provider facilitates the route through the needed services and works in collaboration with other levels and types of provider. Coordination also takes place with other sectors (e.g. social services) and partners (e.g. community organisations).
- **Efficiency:** There is minimal wastage of resources in the achievement of the objectives.
- **Equity:** There is a fair distribution of health facilities and no person will be unfairly discriminated in terms of access to services.
- **Person-centeredness:** Services are organised around the person, not the disease or the financing of health services. They instead recognise and respond to the unique requirements of identified groups (e.g. persons with disabilities and older persons). Users perceive health services to be responsive and acceptable to them. There is participation from the target population in service delivery design and assessment. People are partners in their own healthcare.
- **Quality:** Health services are of high quality, i.e. they are effective, safe, centred on the patient’s needs and given in a timely fashion.

REFUGEES AND UNDOCUMENTED FOREIGN PATIENTS IN SOUTH AFRICA

- Only refugees and asylum seekers with valid immigration documentation will be treated equivalent to a South African citizen.
- Refugees and asylum seekers will be assessed according to their clinical needs and financial status prior to receiving healthcare.
- Any other foreign national (documented, e.g. tourist and undocumented) may only be eligible to emergency and basic healthcare at a public health establishment.

STRUCTURE AND ORGANISATION OF THE REFERRAL NETWORK

The referral network links the different levels of care based on the expected services in terms of the defined package of services (Figure 3). The levels of care include all facilities – community-based services (ward-based PHC outreach teams, integrated school health teams, traditional health practitioners and home-based care organisations), facility-based PHC services, community healthcare centres, specialised hospitals (MDR-TB and mental health) district hospitals; regional hospitals, tertiary hospitals; central hospitals, private general practitioners, private specialist and private hospitals, and EMS.

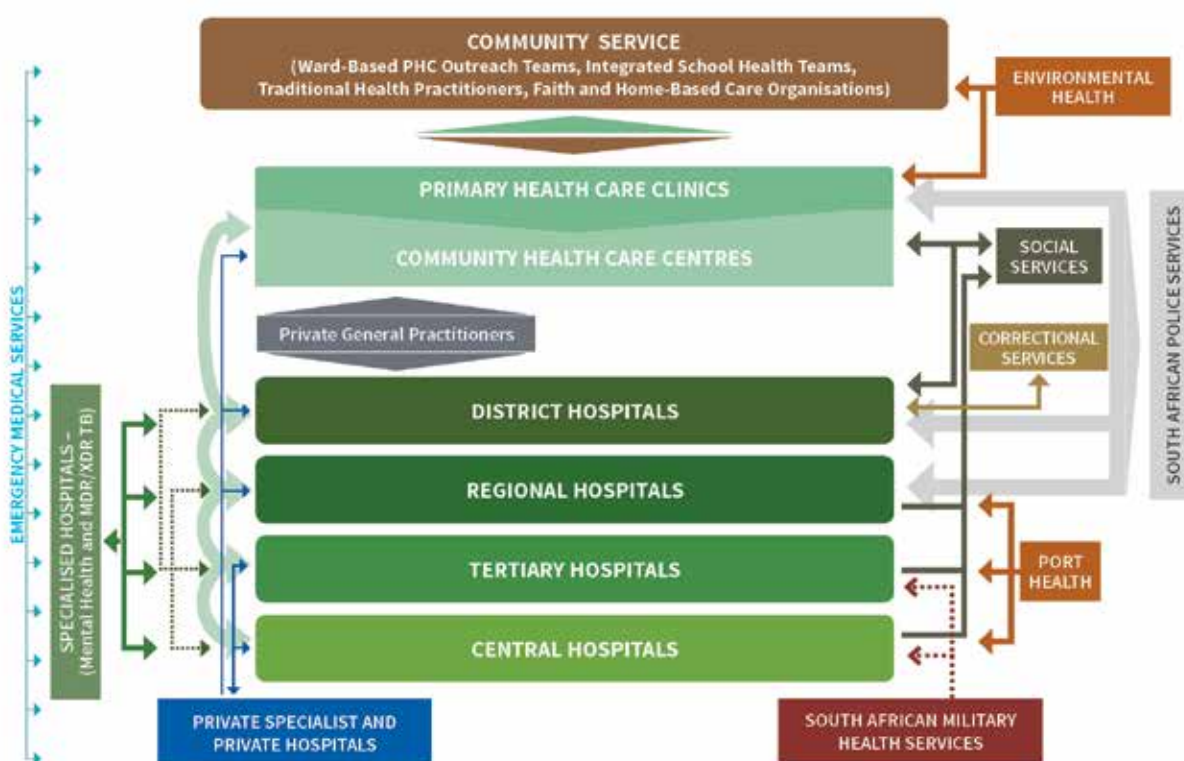


Figure 3: Service Delivery Platform – Integrated Referral Services

A referral system allows for upward and downward (bi-directional) referrals and within and across the entire health system. The availability of services in the receiving facility will guide the referral pattern. EMS support the service delivery platform by providing transport to the appropriate level of care. Any client that is in need of or requires care and procedures that cannot be provided at the initial level of care should be referred to a health service or institution capable of continuing or providing the level of care required.

The district hospital or regional hospital (in specific provincial circumstances) will be the primary point of referral from the PHC level of services. Patients may be directly referred from district hospitals to regional, tertiary, specialised (MDR-TB and specialised psychiatric hospitals) and/or central hospitals. Once the patient's healthcare needs have been met, the patient should be referred to the lowest level of care (within the community) as appropriate for continued support and management.

INDICATIONS FOR REFERRAL

The following is a list of some primary reasons for referring clients who seek emergency or routine care. It is the responsibility of the receiving facility to accept a patient in the following circumstances or make alternative arrangements for the patient if:

- The patient's medical condition requires urgent clinical management.
- The referring facility is not resourced/designated to deal with the patient's medical condition.
- To seek expert opinion and report on the patient's condition.
- Any patient that has a major or life threatening complication after being treated at an initial facility.
- The patient requires observation in order to be assessed or diagnosed.
- The patient requires urgent procedure/s that cannot be performed at the referring institution.
- The patient is a high risk neonate requiring further management.
- The patient is a victim of sexual or child abuse.
- There is a legal requirement for admission, including involuntary treatment under the Mental Health Care Act (No. 17, 2002).
- Patients who are registered organ donors in life threatening situations.
- To respond to mass incidents and disaster situations.
- For continued management, rehabilitation or palliative care at an appropriately designated facility.
- Chronic disease support and care including Home-based care within the community.
- Patients who are eligible to seek healthcare in South Africa and are referred through appropriate channels from another country.

REFERRAL PRINCIPLES

The referral principles provide the overarching guidance in determining the most appropriate health facility that a patient should be able to access health services based on the health condition of the patient.

- Referrals will be to the nearest facility capable of providing the service based on the directory of services (clinical pathways) for the district or province and will not be restricted by geospatial boundaries. A memorandum of understanding for the cost recovery of services provided to the cross border patient's needs to be signed between the concerned districts and provinces.
- A two-way (open) referral system should exist between all referring facilities and all patients who can be appropriately managed at an appropriately designated facility.
- The **initiating facility** (facility that starts the referral process) and the **receiving facility** (facility that accepts the referred case) will record all outward and inward referrals in a referral register. This register will initially be in hard copy but will evolve to an electronic web-based system. Information should include client referred, to where, when and why, whether the case is closed or continuing (the returning referral form has been received with any necessary rehabilitation or follow-up), and whether it was an appropriate referral or if there were any issues.
- An appointment should be scheduled with the relevant institution either telephonically, using mobile applications, e-mail, official electronic media or fax.
- A standardised referral form should be completed and accompany the patient. At minimum, the referral form should include the name, age, gender, presenting complaints, examination and findings, investigations conducted, diagnosis and treatment provided, list of all medicine currently being taken by the patient and any special equipment required for the patient, indication for referral, receiving institution referring practitioner/clinician name, signature and stamp if possible. One copy shall be kept at the initiating facility.
- Where possible, medicine already dispensed to the patient should be taken with the patient to the referral facility for medication reconciliation.
- Depending on the patient's circumstances, the patient may be transferred to the receiving facility using the planned patient transport.

REFERRAL CATEGORIES

Referrals may be categorised as¹²:

- **Emergency referral** An emergency necessitates the immediate transfer of clinical responsibility to the most appropriate health establishment.
- **Non-urgent referral** A consultation with a medical specialist, medical practitioner, nurse clinician or other relevant primary health provider (e.g. physiotherapist, health promoter) as the patient's condition would be better managed through additional support. The receiving healthcare provider specialist will not automatically assume clinical responsibility for ongoing care as the responsibility will vary with the clinical situation.
- **Transfer** The clinical responsibility for the patient's management is transferred to the most appropriate practitioner as warranted by the patient's condition.
- **Down referral** A process in which healthcare providers at higher level's of care who, after managing the clinical condition of the referred patients, may refer the patient back to the original referring facility at a lower level of care or to the community-oriented services for continued management, rehabilitation or palliative care.

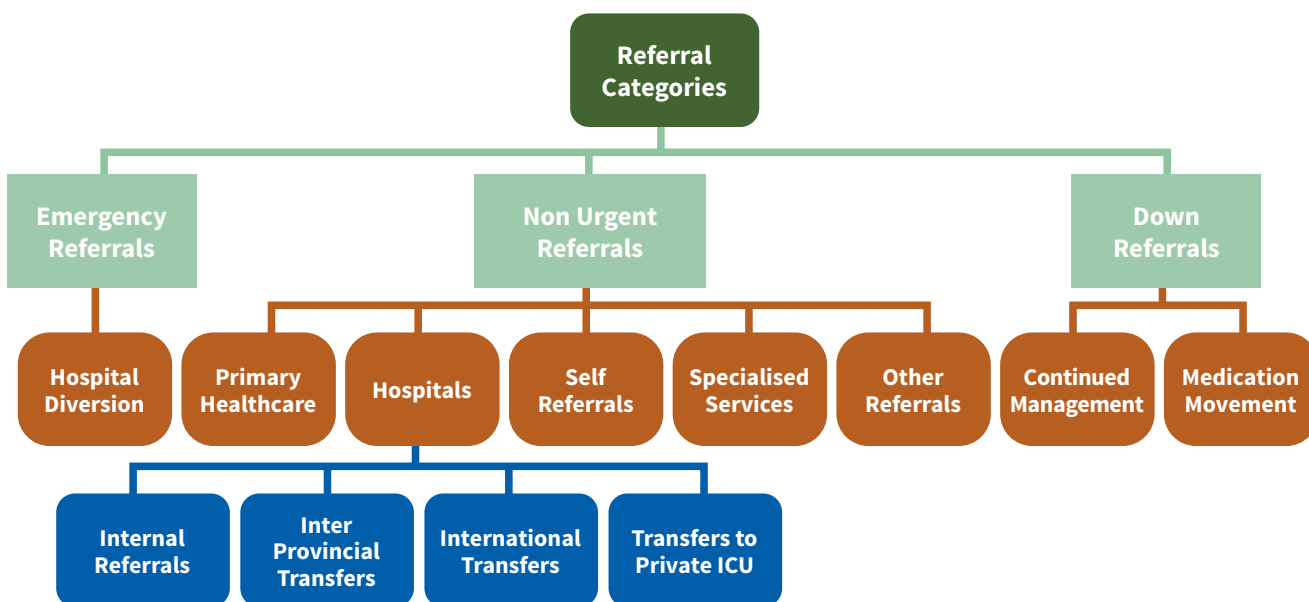


Figure 4: Referral categories in the South African healthcare system

EMERGENCY REFERRALS

- All acute emergencies must be assessed and stabilised based on the skills and resources available. As soon as possible after clinical examination and emergency treatment, the patient should be transferred to the closest appropriate level of care.
- Emergency referrals of aggressive and/or disruptive patients with mental illness must be conducted according to the prescripts of the Mental Health Care Act, 2002 (No. 17).
- The clinical practitioner will identify the facility where the patient needs to be referred (district, regional, specialised, tertiary or central hospital) depending on services required or the clinical care pathway as per provincial referral protocol.
- For critically ill or injured patients, the EMS personnel will consult with the emergency medical doctor at the facility telephonically.
- Inform the patient and accompanying next of kin regarding referral to another facility.

- The attending clinician at the initiating facility should make direct contact with the receiving facility (based on directory of services) telephonically or using mobile applications with appropriate messenger services e.g. WhatsApp or other locally designed applications to facilitate the referral.
- Each facility should ensure that there is a dedicated functional telephone line(s) or dedicated mobile number with appropriate messenger services (e.g. WhatsApp services) for emergency referrals and a published contact list of the doctors on duty per clinical specialty.
- When a decision is made to refer a patient, the EMS call centre must be contacted to activate an ambulance.
- A suitably equipped and licensed ambulance or any other appropriate means of transportation should be available to transfer the patient. When the skills required is beyond the scope of an EMS practitioner, then:
 - EMS must arrange for the resource, or a professional nurse maybe required to accompany the patients.
 - The referring facility should make adequate arrangement for the return of the nurse/practitioner to the facility.
- A standardised referral form and any investigations and reports must accompany the patient to the receiving facility. The referral documentation is to be handed to the emergency care practitioner during the formal handover process prior to transporting the patient of which one copy of the standardised referral form should be retained in the patient's clinical records at the initiating facility and another copy should be kept in the source document.
- Any medicine that the patient is currently taking that has been dispensed to the patient and is available should be provided along with the referral form for medication reconciliation.
- A referral record must be maintained to ensure that the patient can be followed up.
- On arrival of the patient, the medical practitioner/registrar/consultant of the receiving facility who telephonically accepted the patient for transfer should assess and provide the necessary clinical management. In the event that the clinician who originally accepted the patient is not available, it is his/her responsibility to hand over the patient details to a designated colleague to ensure that the patient is not neglected.

Hospital diversion protocol

Provincial specific hospital diversion protocols should be developed that address the following:

- In the event of hospital closure due to capacity constraints, critically ill or injured patients or patients requiring immediate referrals to higher levels of care, EMS will be directed to a designated district/regional/tertiary hospital with the capacity to deal with that patient for the period of closure even if that specific facility is not the designated referral receiving facility for that initiating facility.
- The hospital CEO should consult, notify and obtain approval from the designated provincial hospital/EMS manager for the hospital closure in writing and this must be cascaded to the EMS call centre.

NON-URGENT REFERRALS

Primary healthcare level

- Clients identified at risk during home visits by WBPHCOT or school health visits or by traditional health practitioners (THPs) should be referred to the nearest PHC clinic using the standardised referral form as per Ideal Clinic.
- Patients that are assessed at formal institutions (clinics, hospitals, private practitioners, correctional services, environmental and port health services, social services, etc.) and require medical opinion, or are referred for health supportive services such as physiotherapy, occupational therapy, optometry, nutritional services, social services or assisted medical devices, should receive:
 - An internal referral of a non-urgent nature to the outreach or sessional primary care doctor or allied health practitioners either immediately or on their next visit to the facility using the appointment scheduler.
 - If no doctor or allied health practitioners are available, a referral to the next level of care (CHC, district and regional hospital) based on clinical pathway or services offered is required.

Hospital Level

- The referral to the next level of care is guided by clinical pathways and services offered at the various facilities.
- Referrals from district to regional or regional to tertiary hospitals is reserved for:
 - Specialist consultations.
 - Therapeutic services, e.g. oncology.
 - Investigations not available at the initiating facility.
 - Support services such as physiotherapy, nutritional, laboratory, imaging and other diagnostic services that are not available at the initiating facility.

Internal referrals

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

- Patients with critical or life threatening conditions shall be attended to immediately.
- Prior information (verbal or using an internally developed referral form) must be provided to the practitioner about the referral
- The patients' notes indicating full detailed history, examinations, investigation, findings, treatment and reason for referral is provided to the referred practitioner.
- A non-critical patient shall be responded to as soon as possible. However, it should be within 24 hours.

INTER PROVINCIAL TRANSFERS

In some medical circumstances, a patient will require referral to a tertiary or central hospital that is situated outside the patient's residential province.

The following principles are applicable:

- A service level agreement is required between the respective provinces for inter-provincial transfers as this has budgetary implications but healthcare needs of the patient should not be compromised.
- Each province should develop a standard operating procedure (SOP) for the authorisation, transfer and payment for the services provided by the receiving facility- Refer to *Referral Implementation Guidelines* for SOP.
- Clear guidelines and clinical protocols need to be developed in order not to compromise both local recipients and recipients from external provinces due to resource constraints.
- In line with the protocol, the most senior medical doctor/consultant shall make this referral after contact with the receiving hospital consultant in the other province.

TRANSFER TO PRIVATE ICU'S

- The provincial Department of Health may be required to enter into a service level agreement with private hospitals for the procurement of intensive care unit beds in the likelihood of such a need (labour unrest, major disasters).
- Transfers of patients to the private ICU may only take place after all measures has been exhausted in finding a public sector ICU bed.
- The transfer or referral to the private ICU will require the authorisation of the CEO or Chief Director for hospital services.

PRIVATE MEDICAL PRACTITIONERS/SPECIALIST AND HOSPITALS

Private providers may access the public healthcare system through a district hospital, regional, tertiary or central hospital as appropriate.

- For all non-acute elective referrals, an appointment should be booked based on the directory of services for the province and a referral form should be completed and accompany the patient.
- For emergency referrals, direct contact must be made with the senior registrar or consultant on duty for the appropriate specialist service at the secondary or tertiary hospital.

If the patient requires intensive care, the medical doctor must contact the ICU consultant prior to the transfer.

INTERNATIONAL TRANSFERS

South Africa is a signatory to the SADC protocol and may receive patients from neighbouring countries or may be required to transfer a patient outside the boundaries of the country.

International referrals are directed to the appropriate health institutions and these referrals must follow the institution's administrative guidelines for such referrals in conformity with International Health Regulation 2010.

- For inward international referrals, the referring consultant or referring Department of Health (depending on circumstances) should contact the receiving international facility, consultant and, where necessary, the international liaison of the National Department of Health.
- Patient/relatives must demonstrate proof of possession of all documents necessary for travel.

NON-URGENT SELF-REFERRALS

To counteract and minimise inappropriate self-referrals by patients:

- The district and regional hospitals require a triaging system at the outpatients and accident and emergency units for self-referrals during and after hours if no gateway clinic is available. Patients presenting without a referral letter must be assessed, provided with the required treatment, counselled and referred to the facility closest to their residence using the standardised referral form for further management.
- Medicine may be provided according to the formulary of the health establishment.
- No patient should be refused treatment.
- A by-pass fee may be instituted by regional, tertiary and central health establishments if the patient is an inappropriate self-referral.

SPECIALISED SERVICES REFERRALS

Mental health services

- Each province/district is required to identify and make available to each health facility information on the location of community mental health services and acute, medium to long term, forensic and tertiary mental health services
- Referrals of patients requiring mental health services should be as per the relevant clinical pathway for the different clinical condition and aligned to the Mental Health Care Act.
- Medicines should be provided according to the formulary of the relevant health establishment.

Multi drug resistant (MDR) tuberculosis (TB) and extremely drug resistant TB (XDR-TB)

- Each province/district is required to identify and make available to each health facility information on the location of centralised and decentralised MDR and XDR TB facilities.
- Referral of patients with MDR TB will be informed by the policy framework on decentralised and deinstitutionalised management of XDR and MDR TB for South Africa (2011).
- Medicine should be provided according to the formulary of the relevant health establishment.

Medico-legal referrals

- An official request from the police and other relevant authorities with the official documentation is required for all medico-legal examinations (i.e. sexual assault, gender violence, assault, drunken driving, etc.)
- Informed consent is required from the client prior to any investigations such as blood alcohol level.
- A referral to the appropriate unit (within the hospital or external) for sexual assault or level of care is required for medico-legal requests not within the capability of the health facility concerned.
- A copy of the medico-legal report must be retained in the patient's clinical record.

Forensic medical services

- Any patient that dies as a result of a non-natural death within a health facility will require a post mortem by forensic medical services.
- Any person that dies as a result of a non-natural death outside a health facility will require a post mortem by forensic medical services.
- In both instances, the deceased will be referred to forensic medical services.

Forensic psychiatric services

Courts may require assessment of perpetrators and survivors of crime, especially rape. A referral may be made in circumstances where multiple competencies are required to determine the ability of the perpetrator or victim to testify, consent to sex, which would inform the minimum sentencing legislation.

- High-risk observation patients and high-risk state patients should be referred to the tertiary level forensic services.
- Low-risk and 'minor offences' cases can be attended to by general psychiatrists and other mental healthcare workers.

Perpetrators may be referred to district or regional hospitals where the services may be available.

OTHER REFERRALS

Correctional services

Inmates deemed ill should be referred to the District Hospital with the appropriate referral documentation as outlined in this policy.

South African Military Health Services

- Military personnel will normally be managed by the SAMHS.
- In the event that the required services are not available, the SAMHS health professional should contact the relevant specialist or hospital manager and arrange for a transfer or referral of the patient.
- The standardised documentation as per the Referral Policy should be used.

DOWN REFERRALS

Continued management

- A client may be down referred to the originating health establishment or another receiving health establishment for further treatment, recuperation or rehabilitation after the necessary consultation/treatment has taken place at a higher level of care.
- In other cases, a client who is clinically stable or requires home-based care or health promotion and does not need to make repeated visits to the referral health establishment may be referred to the initiating health establishment or another appropriate lower level health establishment to access the required care.
- Down referrals to the initiating health establishment or another appropriate level of health establishment may take place from a central, tertiary, regional or district hospital.
- In cases where a client moves to a different location, they may be referred to a health establishment at the same level of care, e.g. from one tertiary hospital to another.
- All clients who are referred from one health establishment to another must receive the standardised referral form that provides sufficient information for the receiving health establishment to continue care with a copy being submitted to the original referring doctor/health establishment or community health service.

Medication movement – provision of medicine to clients in the down referral process

There are three main scenarios with regard to the supply of medicine needed by a client who is down referred:

- The client may be referred either to a receiving health establishment where his/her medicine is available on the general formulary of the health establishment.
- He/she may be referred to a health establishment where the medicine needed is not on the general formulary. Special arrangements must be made to enable the client to obtain the medicines needed.
- Where the client continues to receive care at a higher level of care, the referring health establishment continues to supply the medicine required by the patient, with the medicine sent to the receiving health establishment.

Chronic medicine collection programme

- A client who is clinically stable, and does not require monthly attendance at a hospital or clinic and can be managed in the community, may be referred to a chronic medicine collection programme (such as CCMDD or CDU), an adherence club (if available) or a WBOT.
- The client must comply with the relevant eligibility criteria prior to being enrolled on one of the programmes mentioned above
- The referral must be done using the appropriate stationery and completion of the administrative procedures as defined in the applicable guidelines.
- If the client is placed on a chronic medicine collection programme, the dispensing, collection and cost of the medicines will be handled in accordance with the relevant chronic medicine collection programme.

NOTE Collection of medicines using the chronic medicine collection programme is not a down-referral.

Inter provincial medication movement

In provinces where there is no tertiary or central hospital services and medicine prescribed is not on the provincial formulary, special arrangements must be made to enable the client to obtain the medicines needed.

The cost of the medicine must be carried by the province where the receiving facility is located.

- First month's supply (of all medicines on the prescription) to be dispensed by the pharmacy at the tertiary and central hospitals.
- If the medicine required is not on the formulary of the receiving health establishment but an appropriate prescriber is available, the receiving health establishment must make arrangements for access to the medicine on an individual access basis.
- In the case of a hospital or community health centre, the responsible pharmacist of the receiving health establishment must submit an individual client application within one week of the patient visiting the receiving health establishment to the pharmaceutical and therapeutics committee of that health establishment or province for the supply of the medication.
- This will then allow the medication to be ordered via the CCMDD programme and the medication will then be available at the dispensing point.
- The medication cost will then be debited to the relevant province.

EMERGENCY MEDICAL SERVICES

EMS support the service delivery platform through ambulance services, aeromedical services and planned patient transport services. Ambulance services are required to transfer acutely ill or injured patients between their homes and nearest health facility (pre-hospital) as well as between the various levels of facilities (inter-facility transfers).

Planned patient transport services are available for all non-emergency patients referred for consultation, from one health institution to another that is a significant distance away.

PRE-HOSPITAL EMERGENCY ENVIRONMENT

- Clients will access EMS through the Call Centre - 112.
- The communication centres should be operated by staff that have a minimum of a basic ambulance assistant qualification and be registered with the Health Professional Council.
- Patients should be triaged according to a universally accepted South African pre-hospital triage scale and be transported to the relevant facility-based on clinical pathways.
- There should be coordination mechanisms between all stakeholders involved in the management of the patients requiring emergency medical care in the pre-hospital setting and transport to an appropriate level health establishment.
- All health facilities / emergency units must accept all emergency cases; irrespective of the level of care.
- For critically ill or injured patients, the EMS personnel will consult with the emergency medical doctor at the facility telephonically.
- In the case of transport to another facility, continuous medical care should be ensured.
- The practitioner (nurse or doctor) at the receiving facility are required to sign the pre-hospital medical emergency forms completed by the EMS crew.
- Patients will be managed and medicine provided according to the formulary of the health establishment at which the patient receives emergency care.

INTER FACILITY TRANSFER

- The referring clinical practitioner should contact the EMS call centre using the call centre number: 112.
- The referring clinician will provide full administrative and clinical details and special requirements to the call centre operator. A suitably equipped ambulance or any other appropriate means of transportation available is required to transfer the patient. When the skills required is beyond the scope of an EMS practitioner then;
 - EMS must arrange for the resource or a professional nurse may be required to accompany the patients.
 - The referring facility should make adequate arrangement for the return of the nurse/practitioner to the facility
- A standardised referral form and any investigations and reports will accompany the patient to the receiving facility. The referral documentation is to be handed to the emergency care practitioner during formal handover process prior to transporting the patient.

PLANNED PATIENT TRANSPORT SERVICE (PPTS)

- Each province should have a SOP for PPTS that considers the healthcare provision available within the sub-district, district and tertiary facility/ies. The SOP may also include a provision for inter provincial PPTS.
- Each district should have access to PPTS vehicles for transporting patients to higher levels of care.
- The vehicles should be appropriately equipped to transport patients, including stretcher and persons with disabilities.
- A daily/monthly schedule should be available within designated areas at the hospital.

- A central booking point or designated individual at each facility shall be responsible for providing the list of patients to the PPTS unit.
- Accompanying relatives will only be allowed in exceptional circumstances as determined by each province.

AEROMEDICAL SERVICES

- If the receiving consultant or attending clinician is of the opinion that the patient requires and meets the criteria for aeromedical transportation then the consultant, senior medical officer should contact the EMS communication centre after arranging with the receiving facility.
- EMS will coordinate the response.
- A completed referral form and all investigations should be provided with the patient.
- The aircraft must be suitably resourced with equipment, supplies and personnel.

INSTITUTIONAL FRAMEWORK FOR POLICY IMPLEMENTATION

This section of the policy focuses on the governance and institutional frameworks required to support the implementation of the Referral Policy, and how to ensure maximum public value. The roles of the different spheres of government, health facilities, private sector, non-governmental organisations, emergency medical services, referring and receiving healthcare personnel and the client are articulated. The Referral Policy is to be implemented across all levels of the service delivery platform. It is important that all stakeholders fulfil their respective roles and responsibilities to optimise health service delivery.

RESPONSIBILITIES OF THE NATIONAL DEPARTMENT OF HEALTH

- Formulate the overall *Referral Policy for South African Health services and Referral Implementation Guidelines*.
- Support the dissemination and training of health workers on the *Referral Policy for South African Health services and Referral Implementation Guidelines*.
- Design and disseminate standard referral tools including referral forms and registers.
- Provide technical assistance and build capacity to strengthen the referral system at the provincial level.
- Coordinate the development, review and implementation of the Standard Treatment Guidelines and Essential Medicines List to inform formularies.
- Undertake overall performance monitoring of the referral system in South Africa.

RESPONSIBILITIES OF THE PROVINCIAL HEALTH DEPARTMENTS

- Formulate a provincial specific referral policy and SOPs for referrals.
- Undertake performance monitoring and evaluation of the referral system within the province.
- Ensure the availability of standard referral tools, such as referral forms, registers and other relevant forms for referrals at each facility.
- Develop the necessary infrastructure to support the referral system including EMS.
- Ensure availability of financial, human and other resources to support the referral system.
- Ensure continuous supportive supervision and capacity building of facilities in the referral system.
- Formulary development, management and use at provincial level.
- Coordinate the flow of referral information from the province to the NDoH.

RESPONSIBILITY OF THE DISTRICT

- The district should map out and develop a register of services provided by all levels of care in the district.
- The register of services should be updated annually.
- A district specific referral network should be developed in collaboration with all facilities.
- Undertake performance monitoring and evaluation of the referral system.
- Ensure the availability of standard referral tools, such as referral forms, registers and other relevant forms for referrals at the facility level.
- Ensure availability of financial, human and other resources to support the referral system.
- Ensure continuous supportive supervision and capacity building of facilities in the referral system.

- Coordinate the flow of referral information from community health services and facilities to the health management in the province.

RESPONSIBILITY OF THE INITIATING REFERRAL FACILITY

- Perform continuous monitoring of the process of referral in the facility and institute corrective measures if necessary.
- Ensure that staff members are adequately trained on the referral process.
- Ensure the continuous supply of standardised referral forms and registers to the healthcare providers.
- Keep the directory of health services and facilities in a defined geographic area or a referral network.
- Ensure proper recording of all referrals.
- Develop and maintain mechanisms to track referrals in and out of the facility.
- Ensure that the patient and relevant documentation is ready for transportation by EMS at the scheduled time.

RESPONSIBILITY OF THE RECEIVING REFERRAL FACILITY

- Continuously monitor the facility's referral processes to identify gaps and strengths and put in place corrective measures where necessary.
- Ensure that staff members are adequately trained on the referral process.
- Ensure that there is a continuous supply of registers and forms to record referrals.
- Provide patient education to clients on the referral processes and appropriate referral behaviour.
- Keep and continually update a directory of services.
- Ensure that referred clients are seen by appropriate experts or are provided with expected services.
- Ensure that all investigations and documents accompanying the referral from the referring facility protect clients from unnecessary cost.
- Ensure that all prescheduled referrals are processed without undue delay.
- Develop and maintain a mechanism to track referrals in and out of the facility.
- Provide feedback on referrals to the referring facility.

RESPONSIBILITIES OF THE REFERRING HEALTHCARE PERSONNEL

- The referring healthcare personnel should know what, whom, when, and where to refer as guided by the Clinical Management and Referral Guidelines, Health Sector Referral Guidelines and the Directory of Health Services.
- Complete the standard referral form with all the necessary information and attach relevant documentation.
- Explain to the client the need for referral, reasons for choice of doctor or facility, preparation, expected cost and possible outcome of referral.
- Ensure counselling of the clients on the need for referral and maintenance of confidentiality.

RESPONSIBILITIES OF THE RECEIVING HEALTH TEAM/PERSONNEL

- The receiving health team should respond promptly to referral consultation requests.

- Provide appropriate management and report in detail all pertinent findings and recommendations to the referring health worker and, if necessary, the client on opinions that affect his or her healthcare.
- Provide feedback with all required information and recommendations to the referring health facility and the client.
- Communicate with the client or the client's family.

RESPONSIBILITIES OF EMERGENCY MEDICAL SERVICES

- Upon receiving the request for referral, EMS must allocate the patient to the appropriate scheduled referral route and advise the referring and receiving facilities accordingly.
- Take over the patient to be referred from the medical officer or professional nurse of the referring hospital for proper handing over of patient to the referral hospital.
- Ensure that all necessary health records and patient documents from the referring hospital are received by the referral hospital.
- Provide ongoing monitoring, clinical care as necessary and ensure safety of the patient during transportation of the patient.
- Ensure that the patient is formally handed over to the medical officer or professional nurse at the referral hospital, with all health records.

RESPONSIBILITIES OF THE CLIENT

- The client should access the health service at the lowest level of care closest to their home.
- In the event of a referral, the client or next of kin should provide consent for the referral. Clients or next of kin who refuse consent for a referral or transfer should sign a form indicating that they are acting against medical advice.
- After the transfer back to the initiating facility, the client should provide the healthcare worker at the initiating facility with all the documents provided by the receiving facility.
- Patients should respect the transport protocols of EMS in terms of departing times and alighting points.

MONITORING

A performance monitoring system is required to ensure proper functioning of the system. Patient referral indicators will be incorporated into the District Health Information System. Monthly and quarterly reports are generated to indicate trends, gaps and progress in the referral chain and must be communicated to management.

INDICATOR	DESCRIPTION	CALCULATION	MEASUREMENT LEVEL	FREQUENCY OF REPORTING
CLIENT REFERRAL RATE	Number of referrals per 100 patients	Numerator Number of referrals across all facilities Denominator Total number of outpatient visits	National, provincial district and facility	Annual
COMMUNITY HEALTH SERVICES REFERRAL RATE	Percentage of patients consulted by THP/ CHW/NGO's port health/environmental health referred	Numerator Number of referrals received from Community Health services Denominator Total number of patients consulted by CHW	National, provincial district and facility	Quarterly
PHC REFERRAL RATE	Percentage of patients referred to PHC clinics from the community health services	Numerator Number of referrals received from community health services Denominator Total number of outpatient headcount	National, provincial district and facility	Quarterly
HOSPITAL REFERRAL RATE	Proportion of patients referred to and from district hospitals to higher levels of care	Numerator Number of patients referred from lower levels of care to district hospitals and from district hospitals to higher levels of care Denominator Total number of outpatient headcount in the district hospital	National, provincial district and facility	Quarterly
REFERRAL FEEDBACK RATE	Percentage of referrals in which feedback was received from the receiving facility	Numerator Number of referrals in which feedback was received from the receiving facility Denominator Total number of patients referred	National, provincial district and facility	Quarterly

<p>SELF-REFERRAL RATE</p>	<p>Percentage of patients attending district/ regional hospitals without a referral</p>	<p>Numerator Number of attending district/ regional hospitals without a referral ----- Denominator Total number of outpatient headcount patients</p>	<p>National, provincial district</p>	<p>Quarterly</p>
<p>DOWN REFERRAL RATE</p>	<p>Percentage of PHC patients down referred to lower level of care for continued management</p>	<p>Numerator Number of PHC patients down referred to lower level of care for continued management ----- Denominator Total number of outpatient headcount patients</p>	<p>National, provincial district and facility</p>	<p>Quarterly</p>
<p>INTER PROVINCIAL REFERRAL RATE</p>	<p>Percentage of patients referred between provinces</p>	<p>Numerator Number of referrals between province ----- Denominator Total number of outpatient headcount patients</p>	<p>National and Provincial</p>	<p>Annually</p>

IMPLEMENTATION OF THE POLICY

- Guidelines including templates to support implementation have been developed.
- Each province should establish a multi-disciplinary referral coordination structure with district representation.
- An analysis of the service delivery platform capacity, capabilities and resources should be conducted.
- Province and district specific referral pathways and SOP should be developed.
- Engagement with communities and other stakeholders to provide information and advocate for the compliance to the referral guidelines should take place.
- Capacity building initiatives on the referral pathways and utilisation of the appropriate communication platforms and documentation with healthcare personnel across all service delivery platforms should be conducted.
- A flexible and incremental approach will be utilised to implement the policy.

FINANCIAL IMPLICATIONS

There is no additional service financial budgetary implications of the policy as it is already embedded and pertains to service delivery responsibilities of the various provinces. This policy serves to formalise institutional arrangements.

POLICY REVIEW

A policy review should be undertaken every five years or according to changes in the service delivery platform.

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Referral Implementation Guidelines



health

Department:
Health
REPUBLIC OF SOUTH AFRICA

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INTRODUCTION

BACKGROUND

The public healthcare system in South Africa is organised in a hierarchical manner with the District Health System (DHS) based on the principles of primary healthcare (PHC)¹ forming the base of the pyramid. Ward-based PHC outreach teams (WBOPHCT) and integrated school health teams offer health education, health promotion and screening at a community level, whilst the district clinical specialist team provide mentoring, supervision, clinical supportive and outreach services for PHC clinics².

The PHC clinic is the first formal institutional point of contact with the health services. Patients will be able to present at the PHC clinics with any healthcare requirement (whether for promotive, preventive, curative, rehabilitative, palliative or community-based mental health) and will either receive the care they need based on the defined package of services at this level or will be referred to a hospital if more specialised services are necessary (Figure 1).

District hospitals form part of the district health system, support primary healthcare on one hand, and act as a gateway to more specialist care on the other. The district hospital provides level 1 (generalist) services to in-patients and outpatients (ideally on referral from a community health centre or clinic)³. In some circumstances primary healthcare services are rendered at the district hospital where there is no alternative source of this care within a reasonable distance³. A hierarchical referral relationship

between the various levels of hospitals with patients being referred from district hospitals to regional hospitals then to provincial tertiary hospitals and, if required to national referral hospitals and central hospitals. Specialist, regional (Level 2), tertiary (Level 3) and central (level 4) hospitals provide specialist and sub-specialist services in terms of a defined package of services.

Emergency medical services (EMS) support the service delivery platform through ambulance services, aeromedical services and planned patient transport services (PPTS). Ambulance services are required to transfer acutely ill patients between their homes and nearest health facility as well as between the various levels of facilities (inter-hospital transfers). Aeromedical services provide an air service to transport acutely ill patients from distant referring centres to tertiary or central hospitals. Planned patient transport services are available for all non-emergency patients referred for consultation, from one health institution to another, so that patients reach their referral hospital by the appointment time.

The referral system is a cross-cutting feature of the service delivery platform that will ensure⁴ that the client will receive optimal care at the appropriate level so that clients who need specialist services can access them in a timely way without unnecessarily overburdening the health facility.

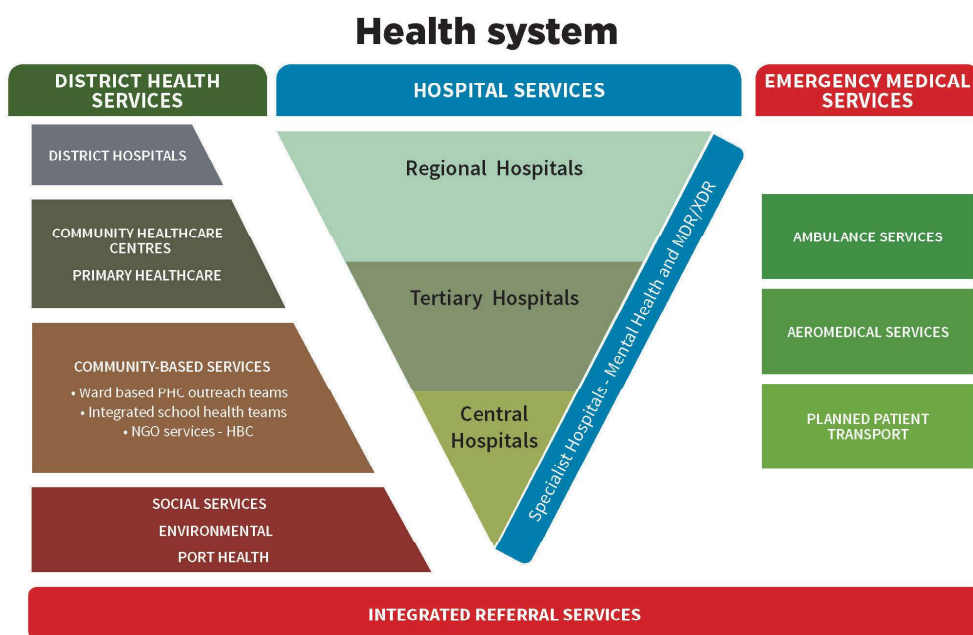


Figure 1: Services across different levels within Health Service Delivery Platform

PURPOSE OF THE GUIDELINES

These guidelines provide all healthcare practitioners involved in the delivery of clinical services and those undertaking the coordination of referral management with a consistent and structured approach to the referral of patients to ensure timely access to comprehensive healthcare services and continuum of care.

SCOPE OF THE GUIDELINES

The guidelines shall be applicable to all stakeholders in the healthcare delivery system across South Africa, in both the public and private sectors.

The guidelines are applicable, but not limited to:

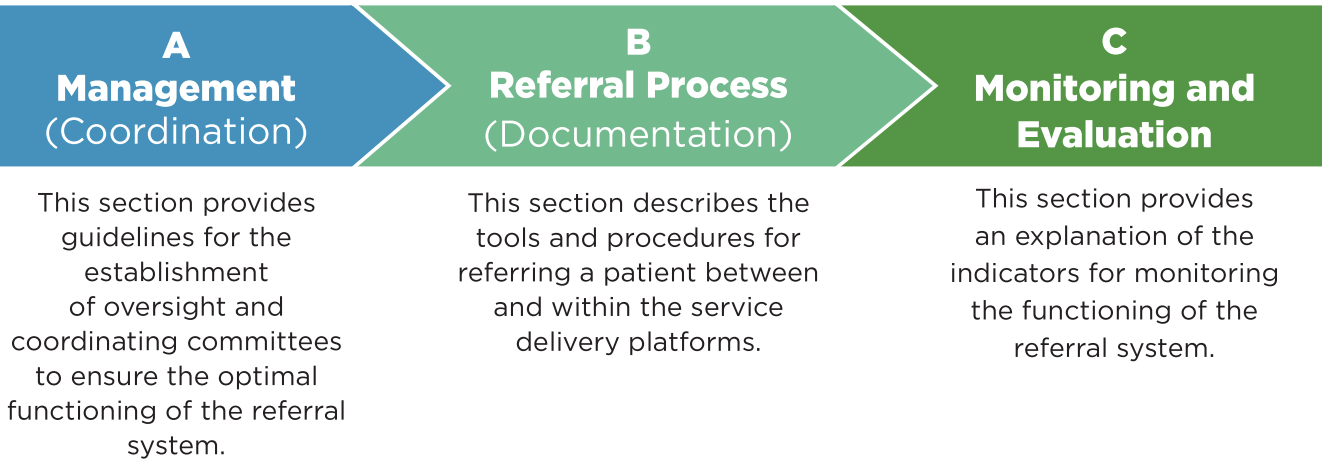
- National government
- Provincial government
- District management
- Hospital/facility management/ administration
- Emergency Medical Services
- Environmental and Port Health
- South African Military Health Services

The following stakeholders are both users and implementers of the policy:

- Public and private healthcare professionals
- Traditional health practitioners
- Community health workers
- NGOs, CBOs, FBOs
- Other government departments:
 - Department of Correctional Services
 - Department of Justice and Constitutional Development
 - Departments of Transport (Road Accident Fund)
 - Department of social development
 - Department of Basic Education
 - Department of Labour (Workmen’s Compensation Fund and Occupational Health and Safety)
 - South African Police Services
- Southern African Development Community (SADC)
 - existing intergovernmental arrangements/treaties

STRUCTURE OF THE GUIDELINES

The *Referral Implementation Guidelines* are organised into three components:



A MANAGEMENT/ COORDINATION/ OVERSIGHT

This section of the guidelines explains how the provincial referral coordinating committee (PRCC) appoints task teams to assist in the oversight and implementation of the *Referral Policy for South African Health Services*. The composition and roles and responsibilities of these task teams are explained. The section also provides tools for developing an index of services and the necessary mapping of referrals for each hospital, district and PHC service.

The availability of services in the facility receiving the referral will guide the referral. The district hospital, where available, or regional hospital (in provincial specific circumstances) will be the primary point of referral from the PHC level of services. Patients may be directly referred from district hospitals to regional, tertiary and/or central hospitals.

OVERSIGHT AND IMPLEMENTATION OF THE *REFERRAL POLICY FOR SOUTH AFRICAN HEALTH SERVICES*

Provincial Referral Coordinating Committee

1. A PRCC should be constituted to provide oversight and leadership in the implementation of the *Referral Policy for South African Health Services* across the province.
2. The hospital referral coordinating task team and district health service referral coordinating task team should be formally appointed through a letter from the head of department (HoD), and the implementation of the referral policy should form part of their performance management development system (PMDS).
3. A senior manager from the provincial office should be delegated to be the responsible person for the PRCC.
4. The senior manager should be held accountable for facilitation of the establishment of the PRCC process and be responsible for reporting to the senior management team on the progress of the implementation of the *Referral Policy for South African Health Services and Referral Implementation Guidelines* across all districts in the province.
6. This committee should consist of:
 - a. Deputy director-general for district health services
 - b. Deputy director-general for hospital clinical support services
 - c. Provincial EMS
 - d. Provincial district health services manager
 - e. Provincial hospital services manager
 - f. Provincial health support services manager**
 - g. Provincial priority programme managers
 - h. Representative from hospital coordinating task team
 - i. Representative from each district referral coordinating committee
 - j. Representative from pharmaceutical services
7. This committee should meet bi-annually to:
 - a. Review performance of the referral system
 - b. Identify common challenges
 - c. Develop relevant action plans (i.e. change route due to non-availability of a specific service that was previously available)
 - d. Develop quality improvement interventions that are time bound.

ROLE OF PRCC

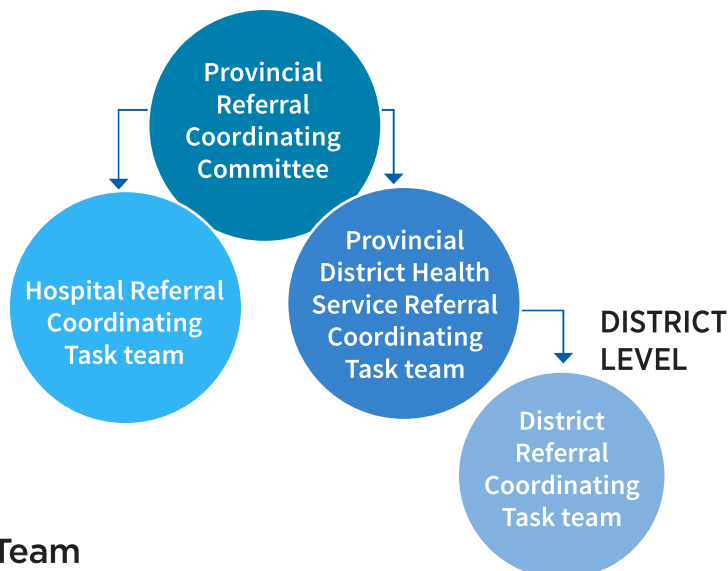
- a. To develop customised referral pathways for the province based on the capacity to deliver the service guided by clinical care pathways and specific criteria for referrals.
- b. To oversee that each hospital develops an index of services available, outpatient clinic schedules and appointment booking protocol.
- c. To oversee that each district has mapped a local referral pattern work with relevant facilities including community services within the catchment area to identify the network of facilities, services, capacity, staff available and distances between facilities.
- d. To develop province wide referral network to access regional, tertiary and central hospital services from district health services.
- e. Monitor and evaluate the performance of the provincial referral system and make recommendations to the HoD on how to improve the performance of individual units or the system as a whole.

** Health support services include amongst others; audiology, eye health, medical orthotics, prosthetics, nutritional support, occupational health, occupational therapy, physiotherapy, oral health, podiatry, speech therapy, social work .

At the Provincial level the PRCC will be assisted by two task teams:

1. The **hospital referral coordinating task team**
2. The **provincial district health service referral coordinating task team**.

Each district will establish a **district referral coordinating task team** which will be represented on the provincial district health service referral coordinating task team.



Hospital Referral Coordinating Task Team

1. The provincial hospital services manager should establish a task team with the head of clinical units at the central/ tertiary and regional hospital for each clinical discipline and health support services as well as representation from pharmaceutical services.
2. The provincial hospital services manager should work with colleagues at the central, tertiary and regional hospital and develop specific guidelines for referrals to higher levels of care based on the capacity to deliver the service guided by clinical care pathways and specific criteria for referrals.
3. This should be communicated across all health establishments (PHC and hospitals) within the province to ensure that access is not compromised.

Provincial District Health Services Referral Coordinating Task Team

The deputy director general district health services or designated senior manager from district health services should establish a task team consisting of representation from district clinical services managers from each district.

1. This committee should meet bi-annually to:
 - a. Review performance of the referral system.
 - b. Identify common challenges.
 - c. Develop relevant action plans (i.e. change route due to non-availability of a specific service that was previously available).
 - d. Develop quality improvement interventions that are time bound.

ROLE OF THE TASK TEAM

To oversee that each district has mapped a local referral pattern network.

ROLE OF THE TASK TEAM

- Map out and develop a register of services provided by all levels of care in the district.
- Develop a district specific referral network in collaboration with all facilities.
- Undertake referral system performance monitoring and evaluation.
- Ensure the availability of standard referral tools, such as referral forms, registers and other relevant forms for referrals at the facility level.
- Ensure availability of financial, human and other resources to support the referral system.
- Ensure continuous supportive supervision and capacity building of facilities in the referral system.
- Coordinate the flow of referral information from community health services and facilities to the health management in the province.

District Referral Coordinating Task Team

Each district health manager should establish a multi-disciplinary referral coordinating task team for the district.

1. This committee should include:

<ol style="list-style-type: none"> a. District manager b. District clinical services manager c. District clinical specialist teams d. District EMS manager e. District priority programme managers f. District information officer g. Hospital medical or nursing services managers 	<ol style="list-style-type: none"> h. Correctional Services i. Social Development j. District clinical specialist teams k. Community health or NGO representative l. Representative from independent practitioners association m. Representative from pharmaceutical services
--	---

2. This district referral coordinating task team should meet on a quarterly basis to review performance of the referral system, identify common challenges and develop relevant action plans or quality improvement programmes.
3. The initial task of this committee is that of working with relevant facilities to identify the network of facilities, services, capacity, staff available and distances between facilities in order to map a **referral pattern (Tool 3)**.
4. All community health services within the district will be required to be mapped.

INDEX OF SERVICES AND MAPPING OF REFERRALS FOR HOSPITALS

The purpose of developing an index of services and mapping of the referrals is to provide health professionals across all levels of hospitals with a clearly identified referral pathway based on availability of services.

Process for Mapping of Services and Developing Directory of Services

1. The CEO/Medical manager at each hospital should establish a multi-disciplinary team comprising clinical service managers, nursing service managers, pharmaceutical managers, health support service managers.
2. This team should develop an index of services available at the respective facilities. Each clinical manager at the central/tertiary/regional hospitals should develop an index of services available at the respective facility.
3. **Regional hospitals**
 - 2.1 **Tool 1A** provides an index of services that are offered at regional hospitals in terms of the package of services. The clinical manager of designated medical specialist will indicate using a ✓ if the listed service is offered at the facility.
 - 2.2 Use **Tool 1B** to record the schedules of outpatient clinics offered by the hospital based on package of services.
4. **Tertiary hospitals**
 - 3.1 **Tool 2A** provides an index of services that are offered at regional hospitals in terms of the package of services. The Clinical Manager of designated medical specialist will indicate using a ✓ if the listed service is offered at the facility.
 - 3.2 Use **Tool 2B** to record the schedules of outpatient clinics offered by the hospital based on a package of services.
5. **Tool 1A, 1B, 2A, 2B** should be analysed by the clinical managers and head of clinical units. Each service within the hospital will develop a referral index of services for regional and tertiary hospital based on available services.
6. The provincial senior management team must approve the index of services, together with the appointment schedules that will be circulated to the district management for mapping out the referral of patients.


**TOOL
1A**

Regional Hospital Services

LIST OF REGIONAL SERVICES	NAME OF HOSPITAL			
(Indicate with a tick or cross for availability of service in each column)				
	HOSPITAL A	HOSPITAL B	HOSPITAL C	HOSPITAL D
Dermatology specialist service				
Diagnostic radiology				
X-ray				
CT scan				
Ultrasound				
Fluoroscopy				
Interventional radiology (basic interventions e.g. image guided aspirations)				
ENT surgery specialist service				
Echocardiography				
Stress ECG				
Regional ICU service				
Diabetes/endocrine clinic				
GIT incl. endoscopy, proctoscopy, sigmoidoscopy, colonoscopy (with general surgery)				
Spirometry and oximetry basic				
Neurology				
Rheumatology				
Pathology services				
Regional dialysis service				
Regional burns unit				
Regional intensive care unit				
General surgery service				
24 hour level II trauma service				
Accident and emergency				
Mental health services				
Acute inpatient and outpatient				
Child and adolescent psychiatry				
ECT				

LIST OF REGIONAL SERVICES	NAME OF HOSPITAL			
(Indicate with a tick or cross for availability of service in each column)				
	HOSPITAL A	HOSPITAL B	HOSPITAL C	HOSPITAL D
Neonatology				
Neonatal low and high care				
Neonatal intensive care				
Obstetrics and gynaecology service				
Emergency				
Standard obstetrics and gynaecology				
Ultrasound				
Basic uro-gynaecology				
Basic oncology, menopause and screening programmes				
Preliminary infertility investigations				
Ophthalmology specialist service				
Orthopaedic surgery				
General paediatric medicine service				
Plastic and reconstructive surgery specialist service				
Urology specialist service				
Vascular surgery specialist service				
Physiotherapy				
Occupational therapy				
Orthotics and prosthetics				
Speech therapy				
Dietetic				
Podiatry				
Acute rehabilitation team including spinal beds				

TOOL 2A

Tertiary Hospital Services

LIST OF TERTIARY SERVICES	NAME OF HOSPITAL			
(Indicate with a tick or cross for availability of service in each column)				
	HOSPITAL A	HOSPITAL B	HOSPITAL C	HOSPITAL D
Dermatology specialist service				
Diagnostic radiology				
X-ray				
CT scan				
Ultrasound				
Fluoroscopy				
Interventional radiology (basic interventions e.g. image guided aspirations)				
ENT surgery specialist service				
Echocardiography				
Stress ECG				
Regional ICU service				
Diabetes/endocrine clinic				
GIT incl. endoscopy, proctoscopy, sigmoidoscopy, colonoscopy (with general surgery)				
Spirometry and oximetry basic				
Neurology				
Rheumatology				
Pathology services				
Regional dialysis service				
Regional burns unit				
Regional intensive care unit				
General surgery service				
24 hour level II trauma service				
Accident and emergency				
Mental health services				
Acute inpatient and outpatient				
Child and adolescent psychiatry				

LIST OF TERTIARY SERVICES	NAME OF HOSPITAL			
(Indicate with a tick or cross for availability of service in each column)				
	HOSPITAL A	HOSPITAL B	HOSPITAL C	HOSPITAL D
ECT				
Neonatology				
Neonatal low and high care				
Neonatal intensive care				
Obstetrics and gynaecology service				
Emergency				
Standard obs and gynaecology				
Ultrasound				
Basic urogynaecology				
Basic oncology, menopause and screening programmes				
Preliminary infertility investigations				
Ophthalmology specialist service				
Orthopaedic surgery				
General paediatric medicine service				
Plastic and reconstructive surgery specialist service				
Urology specialist service				
Vascular surgery specialist service				
Physiotherapy				
Occupational therapy				
Orthotics and prosthetics				
Speech therapy				
Dietetic				
Podiatry				
Acute rehabilitation team including spinal beds				
Cardiology				
Electrophysiology ablation				
ECG halter				
Pacemaker follow-up				
Cath lab				

LIST OF TERTIARY SERVICES	NAME OF HOSPITAL			
(Indicate with a tick or cross for availability of service in each column)				
	HOSPITAL A	HOSPITAL B	HOSPITAL C	HOSPITAL D
Cardiothoracic surgery				
Craniofacial surgery				
Critical care and ICU				
Endocrinology				
Haematology				
Human genetics				
Infectious diseases				
Medical and radiation oncology				
Neurosurgery				
Nuclear medicine				
Obstetrics and gynaecology service				
Oncology				
Urogynaecology				
Reproductive medicine				
Ophthalmology				
Orthopaedic oncology (revision arthroplasty and spinal surgery, basic oncology, paediatric oncology)				
Orthopaedic surgery				
Renal transplant				
Paediatric cardiology				
Paediatric ICU				
Paediatric endocrinology				
Paediatric gastroenterology				
Paediatric haematology and oncology				
Paediatric infectious diseases				
Paediatric nephrology				
Paediatric neurology				
Paediatric respiratory medicine and allergology				
Paediatric rheumatology				



Tool 2B should be completed for each clinic in each hospital and circulated to the referring facilities.

Outpatient Clinics and Contact Details

NAME OF HOSPITAL		NAME OF OUT PATIENT CLINIC		
NAME OF DEPARTMENT		TIME OF OPERATION OF CLINIC		
CONTACT DETAILS FOR APPOINTMENT SCHEDULING				
REQUIRED DOCUMENTS FOR APPOINTMENTS				
Indicate day and time for each specialised clinic				
MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY

TOOL 6

Mapping of Intersectoral Collaborative Services

DISTRICT	SUB-DISTRICT	LOCAL AREA
TEL	EMAIL	
INTERSECTORAL		
South African Police Service		
Department of Home Affairs		
Department of Social Development		
Department of Correctional Services		
Disaster Management Services		

**TOOL
7**

For each PHC/CDC/CHC an index of services offered should be developed. Use **Tool 7** to identify the relevant services offered at the PHC/CDC/CHC. In the column adjacent to the list, identify using a ✓ if available or X if not available.

Mapping of PHC/CDC/CHC Services per Facility

LIST OF PHC SERVICES	NAME OF HOSPITAL			
(Indicate with a tick or cross for availability of service in each column)				
	HOSPITAL A	HOSPITAL B	HOSPITAL C	HOSPITAL D
Emergency care				
Acute/minor ailments				
Adults				
Children				
Chronic diseases				
• HIV				
• TB				
• Mental health - PHC level				
• NCDS				
MCH and SRH				
• Antenatal care				
• Labour ward				
• Post natal care				
• Well baby services including development, growth monitoring and immunisation				
Sexual reproductive health services				
• Male medical circumcision				
• Family planning				
• Doctor - indicate full time or sessional				
• Health support services - indicate onsite or outreach				
Mental health specialist (community health service)				
OT				
Physiotherapy				
Oral health				
Nutrition				
Podiatry				
Speech therapist				
Audiologist				
Psychologist				
Social worker				
Optometry				

TOOL
8

Use **Tool 8** to map out the services offered at the district hospital. In the column adjacent to the list identify using a ✓ if available or X if not available.

Mapping of District Hospital Services

LIST OF PHC SERVICES	NAME OF HOSPITAL			
(Indicate with a tick or cross for availability of service in each column)				
	HOSPITAL A	HOSPITAL B	HOSPITAL C	HOSPITAL D
Emergency care				
Acute/minor ailments				
Adults				
Children				
Chronic Diseases				
• HIV				
• TB				
• Mental health - PHC level				
• NCDS				
MCH and SRH				
• Antenatal care				
• Labour ward				
• Post-natal care				
• Well baby services including development, growth monitoring and immunisation				
Sexual reproductive health services				
• Male medical circumcision				
• Family planning				
• Doctor - indicate full time or sessional				
• Health support services - indicate onsite or outreach				
Mental health specialist (community health service)				
Occupational therapy				
Physiotherapy				
Oral health				
Nutrition				
Podiatry				
Speech therapist				
Audiologist				
Psychologist				
Social Worker				
Optometry				

On completion of the mapping exercise the district referring coordinating task team should be able to visually identify all facilities as well as services offered at each facility in line with the package of services.

In consultation with the Geographic Information System Unit this should be developed into a virtual map and the referral network for each clinic based on location as well as availability of services should be defined.

B REFERRAL PROCESSES/ DOCUMENTATION

This section of the manual details the processes and tools to be used for the different categories of referrals.

Referral refers to the processes by which professionals and institutions communicate and work together to protect, promote and restore the health of an individual. The movement of a patient to another level of care could be internal, upward, downward or lateral. A well-functioning referral system that allows for continuity of care across different tiers of care, is central to the delivery of efficient and effective healthcare working towards achieving universal health coverage. The referral system is not confined to formal health facilities but includes linkages to community-based services and other intersectoral services that address the social determinants of health.

A referral system allows for upward and downward (bi-directional) referrals within and across the entire health system. The availability of services in the receiving facility will guide the referral pattern. EMS support the service delivery platform by providing transport to the appropriate level of care.

REFERRAL CATEGORIES

As shown in Figure 2, referrals may be categorised as:

- **Emergency referral:** An emergency necessitates the immediate transfer of clinical responsibility to the most appropriate health establishment.
- **Non-urgent referral:** A consultation with a medical specialist, medical practitioner, nurse clinician or other relevant primary health provider (e.g. physiotherapist, health promoter) as the patient's condition would be better managed through additional support. The receiving healthcare provider specialist will not automatically assume clinical responsibility for ongoing care as the responsibility will vary with the clinical situation.
- **Transfer:** The clinical responsibility for the patient's management is transferred to the most appropriate practitioner as warranted by the patient's condition.
- **Down referral:** A process in which healthcare providers at higher level of care who, after managing the clinical condition of the referred patients, may refer the patient back to the original referring facility at a lower level of care or to the community oriented services for continued management, rehabilitation or palliative care.

REFERRAL CATEGORIES

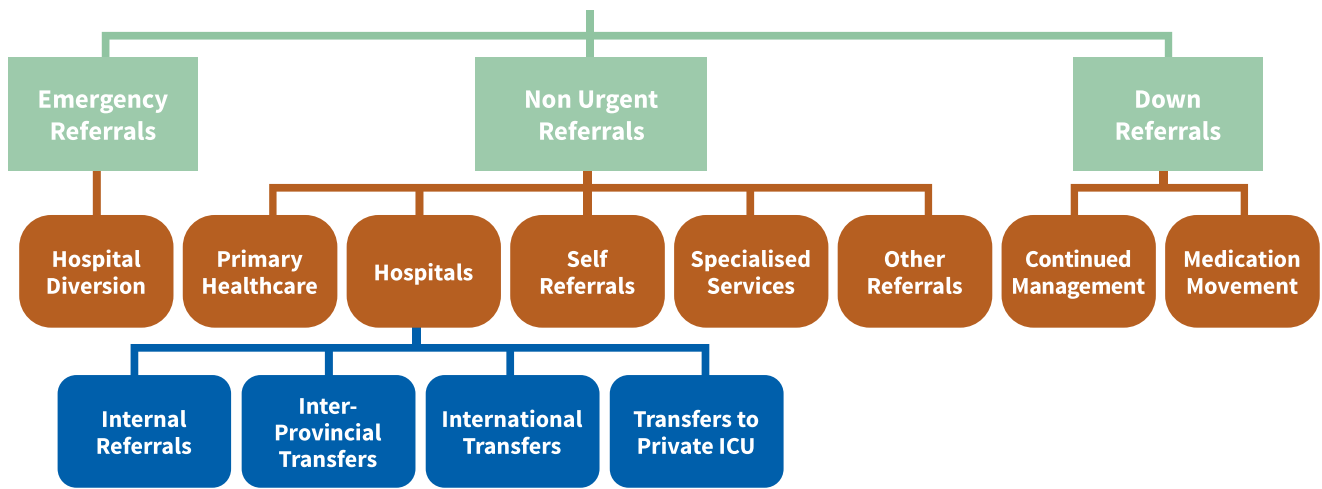


Figure 2: Referral categories in the South African healthcare system

EMERGENCY REFERRALS

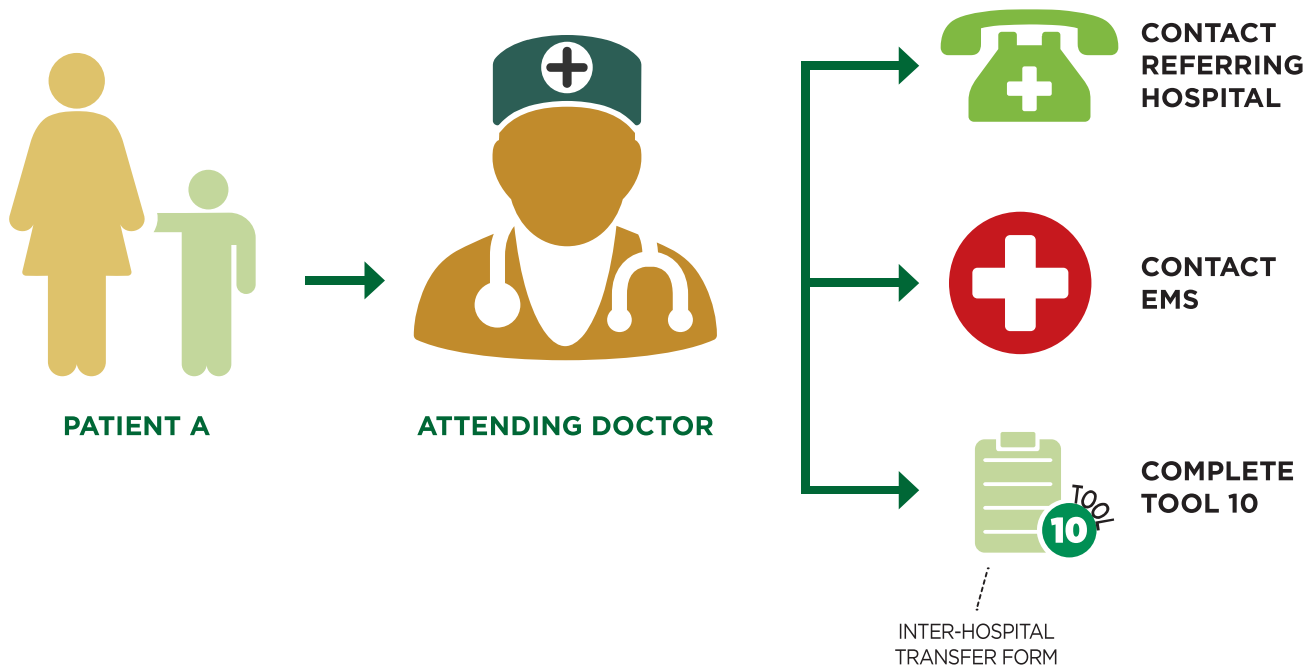


Figure 3: Emergency referral process

In some medical circumstances, a patient will require an emergency referral.

- All acute emergencies must be assessed and stabilised based on the skills and resources available. As soon as possible after clinical examination, and emergency treatment, the patient should be transferred to the closest appropriate level of care.
- Emergency referrals of aggressive and/or disruptive patients with mental illness must be conducted according to the prescripts of the Mental Health Care Act (No. 17, 2002).
- The clinical practitioner will identify the facility where the patient needs to be referred (district, regional, specialised, tertiary or central hospital) depending on services required or the clinical care pathway as per provincial referral protocol.
- For critically ill or injured patients, the EMS personnel will consult with the emergency medical doctor at the facility telephonically.
- Inform the patient and accompanying next of kin of regarding referral to another facility.
- The attending clinician at the initiating facility should make direct contact with the receiving facility (based on directory of services) telephonically or using mobile applications with an appropriate messenger services (e.g. WhatsApp) or other locally designed applications to facilitate the referral.
- Each facility should ensure that there is a dedicated functional telephone line(s) or dedicated mobile number with an appropriate messenger services (e.g. WhatsApp) for emergency referrals and a published contact list of the doctors on duty per clinical specialty.
- When a decision is made to refer a patient, the EMS call centre must be contacted to activate an ambulance.
- A suitably equipped and licensed ambulance or any other appropriate means of transportation should be available to transfer the patient. When the skills required is beyond the scope of an EMS practitioner, then:
 - EMS must arrange for the resource or a professional nurse maybe required to accompany the patient.
 - The referring facility should make adequate arrangement for the return of the nurse/practitioner to the facility.
 - Food should be arranged for both the patient and accompanying personnel for the duration of transport.
- An inter-hospital transfer form (**Tool 10**) and any investigations and reports must accompany the patient to the receiving facility.
- The referral documentation is to be handed to the emergency care practitioner during the formal handover process prior to transporting the patient of which one copy of the standardised referral form should be retained in the patient's clinical records at the initiating facility and another copy should be kept in the source document.
- Any medicine that the patient is currently taking that has been dispensed to the patient and is available should be provided along with the referral form for medication reconciliation.
- A referral record must be maintained to ensure that the patient can be followed up.
- On arrival of the patient, the medical practitioner/registrar/consultant of the receiving facility who telephonically accepted the patient for transfer should assess and provide the necessary clinical management. In the event that the clinician who originally accepted the patient is not available, it is his/her responsibility to hand over the patient details to a designated colleague to ensure that the patient is not neglected.

**TOOL
10**

The referring clinician or professional nurse is required to complete the following form in triplicate prior to handing over the patient to EMS. One should be for the EMS, one for the referral hospital and one should be included in the patient’s clinical record and retained at initiating referral facility.

Inter-hospital Transfer Form



health
Department:
Health
REPUBLIC OF SOUTH AFRICA

PATIENT DETAILS									
First name			Surname						
Address									
			Postal code						
Date of birth	Y	Y	Y	Y	M	M	D	D	Age
Contact number									Gender
Identity number									Weight
Patient file/record number									
Diagnosis and ICD10 code/s									
List of patient allergies									
TO BE COMPLETED FOR TRANSFERS									
Institution name									
Classification of facility	District hospital	Specialised TB hospital	Regional hospital	Specialised mental hospital	Tertiary hospital	Central hospital			
Department referred to									
Receiving doctors name									
Time patient accepted									
Time Transport Booked for patient									
CLINICAL INFORMATION ON PATIENT									
Diagnosis									
Reason for transfer									
Relevant past history									
	Airway	Breathing	Colour	Skin circulation	Pulse	Behaviour			
	Patent	Unremarkable	Unremarkable	Unremarkable	Unremarkable	Harm to self			
	Compromised	Shallow	Pale	Warm/got	Regular	Harm to others			
	Ventilated	Deep	Flushed	Cool/cold	Irregular	Physical restraint			
		Rapid	Mottled	Dry	Slow				
		Slow	Cyanotic	Moist/clammy	Rapid				
		Laboured			Strong				
		Asymmetrical			Weak				
		Audible wheeze			Not palpable				

Airway management plan									
Vital Signs (relevant data only)	Weight	Temp.	Pulse	HB	Resp.	GCS			
Blood pressure		SpO2	HGT	pain score					
Intensive Therapy									
IV/Central line	IV Fluid (type/ml)			IV fluid chart					
NGT/Other	Urinary catheter		Chest/other drains		Oxygen				
SPECIFIC CARE REQUIRED									
Medicine prescribed (INN, dosage form, quantity, route of administration, dosage, frequency and duration of treatment)"									
Mobility									
Hygiene/elimination									
Feeding									
Special needs									
Other									
Skin intact: Yes/no (if no - specify)									
Documents sent with patient (list)									
Valuables/assistive devices sent with patient (list)									
REFERRING INSTITUTION/CLINICIAN DETAILS									
Referring facility name									
Referring practitioner (name)									
Date	Y	Y	Y	Y	M	M	D	D	Time
Signature									
Tel no./e-mail									

NON-URGENT REFERRALS

In some medical circumstances, a patient will require a non-urgent referral.

PRIMARY HEALTHCARE LEVEL

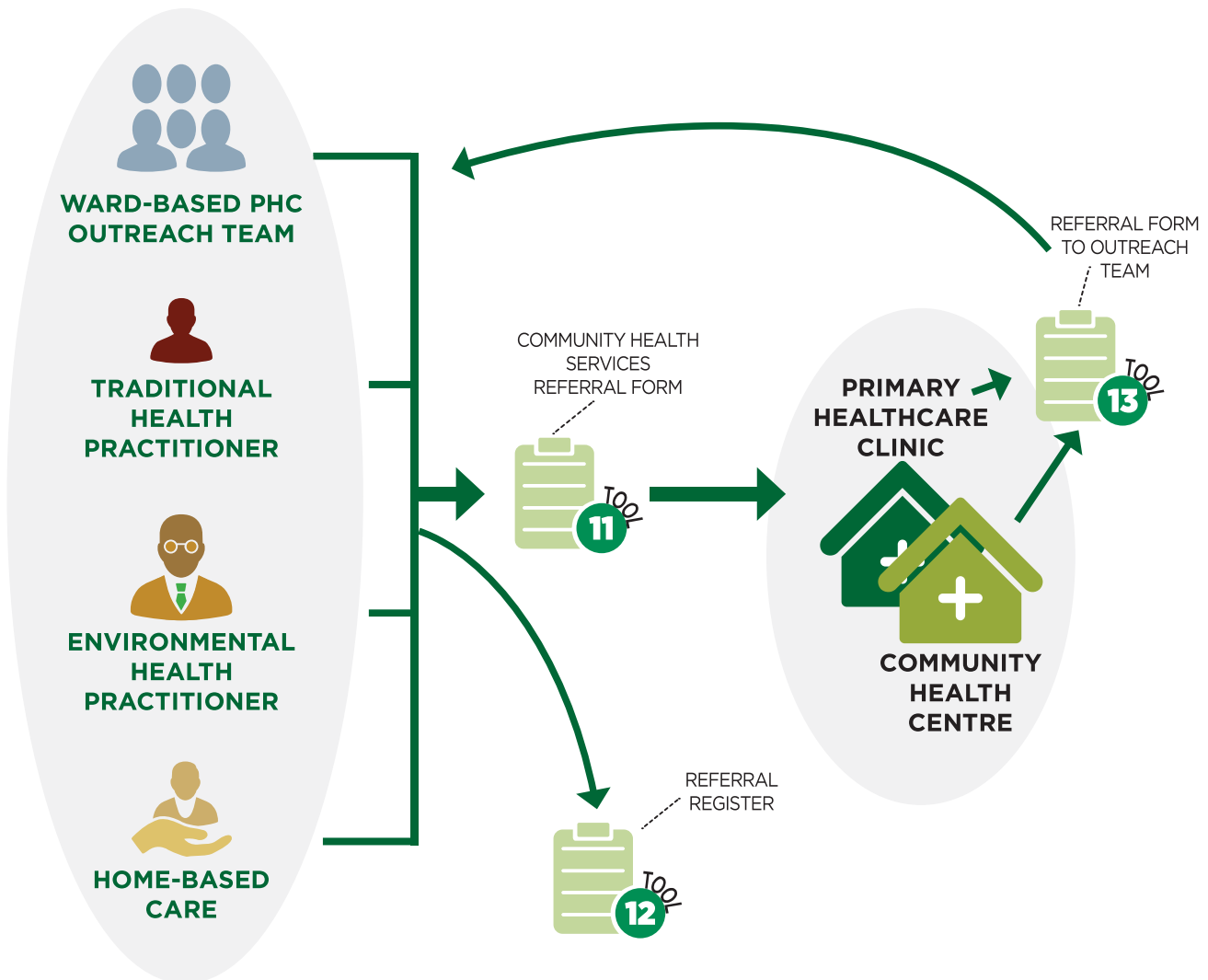


Figure 4: Non-urgent referral process

- The WBPHCOT, traditional health practitioners, environmental health and home-based services should use the standardised referral form as per Ideal Clinic (**Tool 11**) to refer clients to PHC clinics.
- A register recording the referral (name of patients, referral destination, reason for referral, feedback) is required for continuity of care and reporting purposes (**Tool 12**).
- After the patient is consulted as per the referral, feedback will be provided using the standardised stationery (**Tool 13**).

**TOOL
11**

Referral Form

(from Community Health Services to HCP)



health
Department:
Health
REPUBLIC OF SOUTH AFRICA

REFERRAL DETAILS														
DATE OF REFERRAL					Y	Y	Y	Y	M	M	D	D		
REFERRED BY					REFERRED TO									
Community health worker (WBPHCOT) <input type="checkbox"/>					Clinic name									
Environmental health officer <input type="checkbox"/>					Ward number									
Traditional health practitioners <input type="checkbox"/>					Or service									
CONTACT NUMBER OF REFEREE					Home Affairs <input type="checkbox"/>		School <input type="checkbox"/>							
					NGO <input type="checkbox"/>		South African Police <input type="checkbox"/>							
NAME OF REFEREE					Department of Social Development <input type="checkbox"/>									
CLIENT DETAILS														
First name					Surname									
Address														
Postal code														
DATE OF BIRTH					Y	Y	Y	Y	M	M	D	D	Age	
CONTACT NUMBER													Gender	
REASON FOR REFERRAL TO HEALTH SERVICES														
Maternal and sexual reproductive health		Child Health		Assessment			Other							
Antenatal care	<input type="checkbox"/>	PCR test for infants	<input type="checkbox"/>	TB testing	<input type="checkbox"/>	Other health problems (specify below)								
Postnatal care	<input type="checkbox"/>	Newborn care	<input type="checkbox"/>	STI testing	<input type="checkbox"/>									
Pregnancy test	<input type="checkbox"/>	Low birth weight	<input type="checkbox"/>	Mental health	<input type="checkbox"/>									
Family planning	<input type="checkbox"/>	Immunisation	<input type="checkbox"/>	Treatment adherence	<input type="checkbox"/>									
Emergency contraception	<input type="checkbox"/>	Vitamin A	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>									
Cervical contraception	<input type="checkbox"/>	Persistent diarrhoea	<input type="checkbox"/>	High blood pressure	<input type="checkbox"/>									
		Breathing problems	<input type="checkbox"/>	Asthma	<input type="checkbox"/>									
		Nutritional/growth problems	<input type="checkbox"/>	HIV testing	<input type="checkbox"/>									
				Eye health	<input type="checkbox"/>									
REASON FOR REFERRAL TO HEALTH SERVICES														
Child-headed household	<input type="checkbox"/>	Child protection services	<input type="checkbox"/>	Food support	<input type="checkbox"/>	Grant support	<input type="checkbox"/>							
Mental health	<input type="checkbox"/>	Support groups	<input type="checkbox"/>	Housing	<input type="checkbox"/>	Vital documents	<input type="checkbox"/>							
Other (provide further information)				Home-based care (provide further information)										
MEDICINE PATIENT IS CURRENTLY TAKING														
(INN, dosage form, strength, route of administration, dosage)														
Complete the feedback referral form on the other half of the page														
SIGNATURE					DATE									
					Y	Y	Y	Y	M	M	D	D		

REFERRAL FROM SCHOOL HEALTH SERVICES

A child that has been assessed by the integrated school health team and is deemed to require further assessment, should be referred to the nearest applicable health service using the school health service referral letter (**Tool 14**) as per the Ideal Clinic stationery. The child's details should be recorded in the school health referral register (**Tool 15**).

After the child is assessed by the healthcare provider a follow up assessment form should be completed (**Tool 16**) and returned to the school health team.

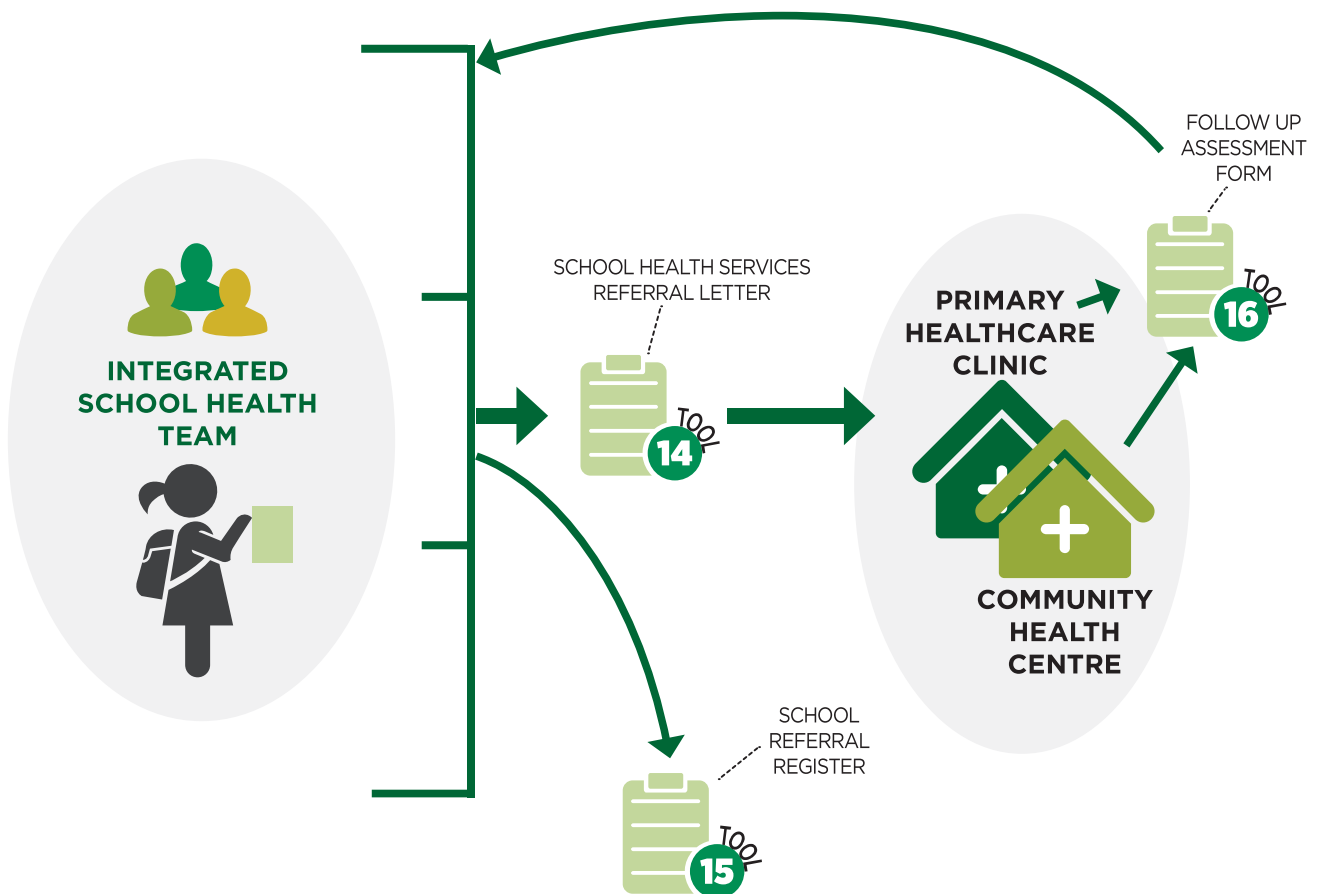


Figure 5: School health services referral process

**TOOL
14**

The school health nurse must complete this form when a child is referred to the PHC/CHC or district hospital.

School Health Service Referral Letter

REFERRAL LETTER TO HEALTHCARE PROVIDER



health

Department:
Health
REPUBLIC OF SOUTH AFRICA

Date _____

Dear colleague

REFERRAL FOR FURTHER ASSESSMENT

During routine health screening it was found that

(Name of learner)

might have a problem with.....

.....

.....

and may require further assessment.

Add findings in as much detail as possible from school health screening form e.g. visual screening left eye 6/18 - severe visual problem in the space provided above.

Kindly complete the attached follow up form indicating the outcomes of the assessment for attention of the school principal.

Yours sincerely

School Health Stamp

SIGNATURE (school health nurse)

PRINT NAME

**TOOL
15**

The PHC/CHC should keep a register of referred patients for continuity of care and reporting purposes.

Register of Learners Referred from School Health Teams

Name of health facility:

Month and year: 20

Name and surname of learner	Grade	Name of school	Reason for referral	Referral date	Date learner seen at facility	Date feedback provided to school health teams

**TOOL
16**

The attending clinician is required to complete the following down referral form.

Follow-up Assessment Form

Date.....
 Name of clinic
 Name of health provider
 Designation (e.g. prof nurse)
 Contact number



health

Department:
 Health
 REPUBLIC OF SOUTH AFRICA

Dear Sir/Madam

FOLLOW UP OF HEALTH ASSESSMENT

The following learner

(Name of learner)

was referred for further assessment as a result of the Integrated School Health Screening Programme.

Further assessment conducted Yes/No **(tick whatever applicable)**.

The child must return to the clinic for further treatment on **(add date)**.

Care and support at school level

The school can assist the child in the following ways

Add simple interventions e.g. sit at the front of the class for vision problems

.....

Please do not hesitate to contact the clinic/private healthcare provider should you require additional information on the following number

_____ (contact numbers)

Yours sincerely

 Name and signature of health professional

School Health Stamp

REFERRAL TO HOSPITALS

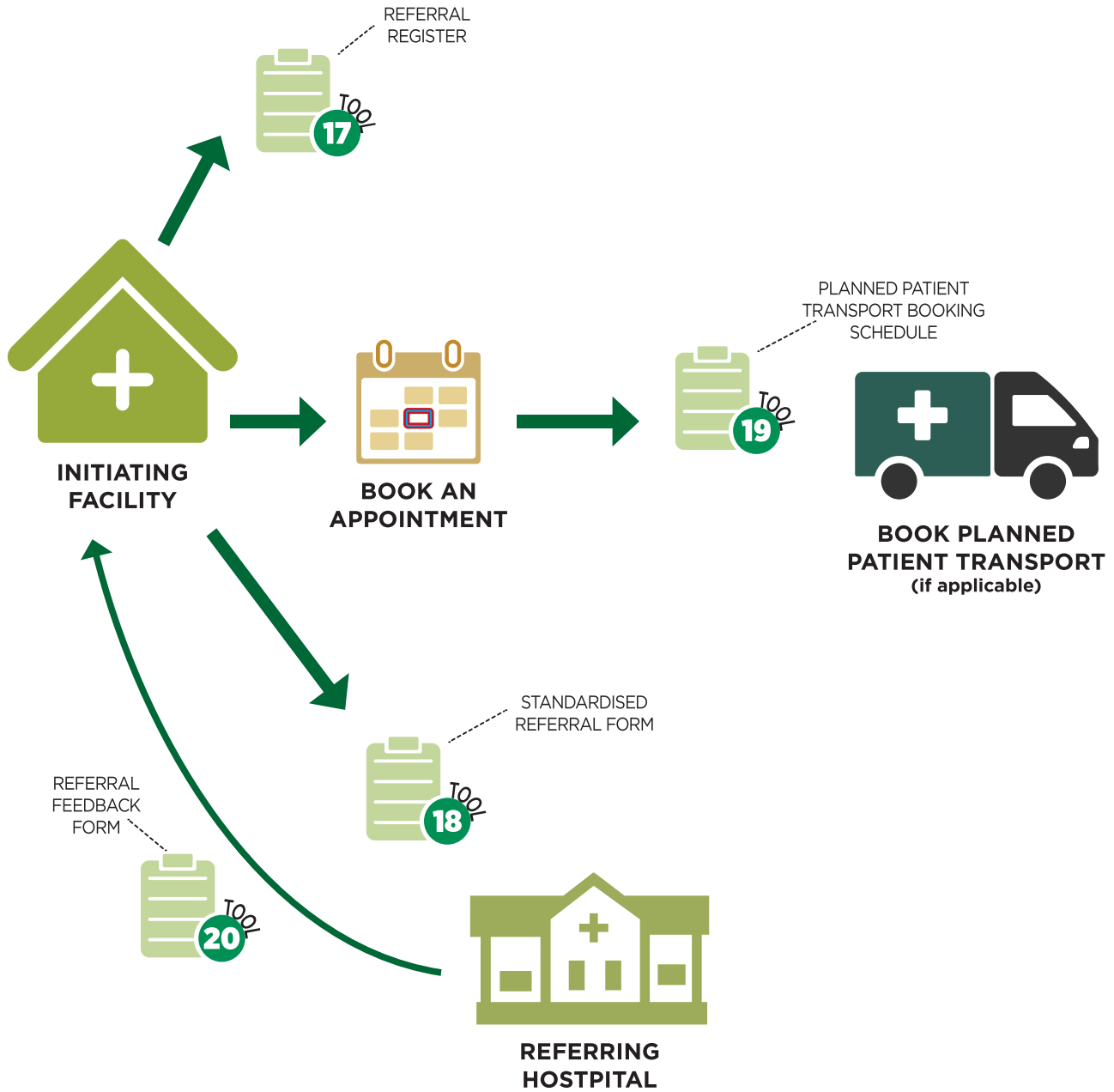



Figure 6: Hospital outpatient referral process

Medication movement - provision of medicine to clients in the down referral process:

- If no doctor or allied health practitioners are available, a referral to the next level of care (CHC, district and regional hospital) based on clinical pathway or services offered is required.
- The referral to the next level of care is guided by clinical pathways and services offered at the various facilities.
- Referrals from district to regional or regional to tertiary hospitals is reserved for:
 - Specialist consultations
 - Therapeutic services e.g. oncology
 - Investigations not available at the initiating facility.
 - Support services such as physiotherapy, nutritional, laboratory, imaging and other diagnostic services that are not available at the initiating facility.
- The **initiating facility** (facility that starts the referral process) and the receiving facility (facility that accepts the referred case) will record all outward and inward referrals in a **referral register**. This register will initially be a hard copy but will evolve to an electronic web-based system. Information should include client referred, to where, when and why, whether the case is closed or continuing (if the returning referral form has been received with any necessary rehabilitation or follow-up), and whether it was an appropriate referral or if there were any issues (**Tool 17**).
- An appointment should be scheduled with the relevant institution either telephonically, using mobile applications, e-mail, official electronic media or fax.
- A **standardised referral form** should be completed and accompany the patient. At a minimum, the referral form should include the name, age, gender, presenting complaints, examination and findings, investigations conducted, diagnosis and treatment provided, list of all medicine currently being taken by the patient and any special equipment required for the patient. It should also include indications for referral, receiving institution, referring practitioner/clinician name, signature and stamp if possible. One copy shall be kept at the initiating facility (**Tool 18**)
- Where possible, medicine already dispensed to the patient should be taken with to the referral facility for medication reconciliation.
- Depending on the patient circumstances, the patient may be transferred to the receiving facility using the planned patient transport. The patient should be booked with the booking clerk for PPT using the **booking schedule** (**Tool 19**)
- Once the healthcare practitioner at the referral institution completes the assessment, discharges or down refers the patient a **referral feedback form** should be completed and submitted to the referring practitioner. (**Tool 20**)

**TOOL
18**

This **standardised referral form** is used for a non-emergency, emergency referrals and transfer of patient from a PHC/CHC/general practitioner to a district hospital or a referral between a district hospital and higher levels of care. This form should be completed in triplicate - one to accompany patient, one in patient's file and the last to remain in the referral book for record keeping purposes.

Standardised Patient Referral Form										 health Department: Health REPUBLIC OF SOUTH AFRICA	
TYPE OF REFERRAL			Emergency <input type="checkbox"/>			Outpatient <input type="checkbox"/>			Transfer <input type="checkbox"/>		
PATIENT DETAILS											
First name						Surname					
Next of kin if patient is a minor - first name						Surname					
Address						Postal code					
Date of birth		Y	Y	Y	Y	M	M	D	D	Age	
Contact number										Gender	
Identity number (if available)										Weight	
Patient file/record number											
TO BE COMPLETED FOR EMERGENCY REFERRALS/TRANSFERS											
INSTITUTION NAME											
Classification of facility		District hospital	Specialised TB hospital	Regional hospital	Specialised mental hospital	Tertiary hospital	Central hospital				
Department referred to											
Receiving doctors name											
Time patient accepted											
Time transport booked for patient											
CLINICAL INFORMATION ON PATIENT											
CURRENT MEDICAL HISTORY											
RELEVANT PAST HISTORY											
VITAL SIGNS: (RELEVANT DATA ONLY)		Blood pressure	Weight	Temp.	Pulse	HB	Resp.	GCS	HGT		
HIV INFORMATION		Viral load		CD4							
TB INFORMATION		Chest X-ray				GeneXpert					
		Sputum One	Date:	Results	Sputum Two	Date:	Results				

RELEVANT CLINICAL EXAMINATION FINDINGS									
DIAGNOSIS									
CATEGORY OF TB	New case <input type="checkbox"/>	Re-treatment <input type="checkbox"/>	Smear negative <input type="checkbox"/>	Chronic - MDR <input type="checkbox"/>	Chronic- XDR <input type="checkbox"/>	XDR review <input type="checkbox"/>			
INVESTIAGIONS AND FINDINGS (ATTACH RESULTS)									
MEDICINE PRESCRIBED (INN, DOSAGE FORM, QUANTITY, ROUTE OF ADMINISTRATION, DOSAGE, FREQUENCY AND DURATION OF TREATMENT)”									
REASON FOR REFERRAL									
REFERRING INSTITUTION/CLINICIAN DETAILS									
Referring facility name									
Referring practitioner name									
Professional council registration number									
Date	Y	Y	Y	Y	M	M	D	D	Time
Signature									
Tel no./e-mail									

**TOOL
19**

The hospital should maintain a planned patient transport services (PPTS) booking schedule based on the roster of services and capacity of the vehicle.

Planned Patient Transport Booking Schedule

PATIENT TRANSPORT BOOKING AND TRANSPORT SCHEDULE								
BOOKING REGISTER								
DATE OF SERVICE					DAY OF WEEK		PATIENT TRANSPORTED	
	Patients name	Referral hospital	Ward clinic	Receiving hospital	Clinic/ward	Mode	Yes	No
1								
2								
3								
4								
5								
6								
7								
8								
9								
10								
11								
12								
13								
14								
15								
16								
17								
18								
19								
20								
21								
22								
23								
24								
25								
26								
27								
28								
29								
30								
Transport officer's signature				REMARKS				
Date Y Y Y Y M M D D								



Standardised Patient Referral Feedback Form



health

Department:
Health
REPUBLIC OF SOUTH AFRICA

STANDARDISED PATIENT REFERRAL FEEDBACK FORM																
FEEDBACK TO																
Institution name																
Department referred from																
Referring practitioner																
Appointment/referred date																
Appointment reference number																
Tel no./e-mail																
PATIENT DETAILS																
First Name:						Surname										
Next of kin if patient is a minor - first name						Surname										
Address						Postal code										
Date of birth	Y	Y	Y	Y	M	M	D	D	Age							
Contact number									Gender							
Identity number (if available)									Weight							
Patient file/record number																
CLINICAL INFORMATION ON PATIENT																
Brief history of presenting symptoms and initial diagnosis																
Primary, secondary diagnosis and co-morbidities at referral institutions																
Investigations and findings (attach results)																
Procedures performed and results thereof																
Medicine prescribed (INN, dosage form, quantity, route of administration, dosage, frequency and duration of treatment)																
Details of ongoing management required																
Has a prescription for non EDL medication been issued and submitted to district pharmacy/referring hospital	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>	Date				Y	Y	Y	Y	M	M	D	D
					Submitted via				Email	<input type="checkbox"/>	Fax	<input type="checkbox"/>	Hard copy <input type="checkbox"/>			
Patient to be seen again at referral institution	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>	Date of next appointment				Y	Y	Y	Y	M	M	D	D
FEEDBACK FROM (REFERRAL INSTITUTION)																
Referring facility name																
Referring practitioner (name)																
Date	Y	Y	Y	Y	M	M	D	D	Time							
Signature																
Professional council registration number																
Tel no./e-mail																

INTERNAL REFERRALS BETWEEN DISCIPLINES WITHIN THE SAME INSTITUTION

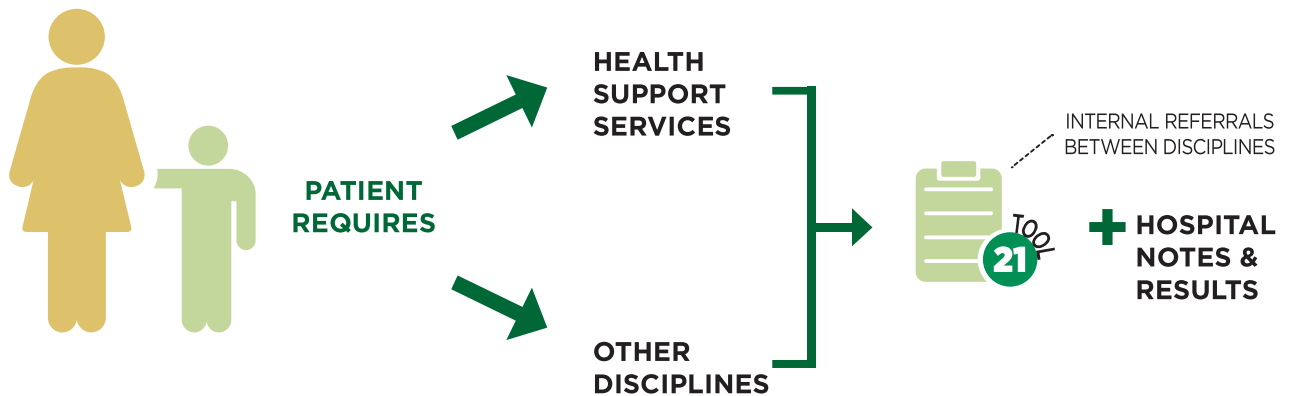


Figure 7: Internal referral process

Patients that are assessed at formal institutions (clinics, hospitals, private practitioners, correctional services, environmental and port health services, social services etc.) and require medical opinion, or referral for health supportive services such as physiotherapy, occupational therapy, optometry, nutritional services, social services, assisted medical devices should receive:

- A non-urgent, internal referral to the outreach or sessional primary care doctor or allied health practitioner either immediately or on their next visit to the facility. The appointment scheduler should be used..

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

- Patients with critical or life threatening conditions shall be attended to immediately
- Information must be provided to the practitioner prior to referral (verbally or using an internally developed referral form).
- The patients' notes indicating full detailed history, examinations, investigation, findings, treatment and reason for referral is provided to the referred practitioner.
- A non-critical patient shall be responded to as soon as possible, but within twenty-four hours.
- When patients are referred internally, the internal referral letter should always be accompanied by the patient's clinical records. This referral form is used for clinical care referrals and not radiology and laboratory as they have defined forms.

**TOOL
21**

Standardised Internal Patient Referral Form



health

Department:
Health
REPUBLIC OF SOUTH AFRICA

TYPE OF REFERRAL	Emergency <input type="checkbox"/>	Outpatient <input type="checkbox"/>	Transfer <input type="checkbox"/>
PATIENT DETAILS			
First Name:			Surname:
Next of kin if patient is a minor - First Name:			Surname:
Address:			Postal Code:
Date of birth	Y Y Y Y M M D D	Age:	
Contact number		Gender:	
Identity number (if available)		Weight:	
Patient file/record number			
CLINICAL INFORMATION ON PATIENT			
Medical History			
Relevant past history			
Relevant Clinical Examination Findings			
Summary of Investigations and Findings			
Diagnosis			
Medicine Prescribed (INN, dosage form, quantity, route of administration, dosage, frequency and duration of treatment)"			
Reason for referral			
TO BE COMPLETED FOR EMERGENCY REFERRALS/TRANSFERS			
CLINICIAN DETAILS			
Referring Department			
Referring Practitioner (Name):			
Date:	Y Y Y Y M M D D	Time:	
Signature:			
Tel No./e-mail:			
Professional Council Registration Number:			
Appointment Date	Y Y Y Y M M D D		
Appointment Made with			
Tel No./e-mail:			

INTER-PROVINCIAL REFERRAL TO TERTIARY AND CENTRAL HOSPITALS

In some medical circumstances, patient will require referral to a tertiary or central hospital that is situated outside the patient's residential Province.

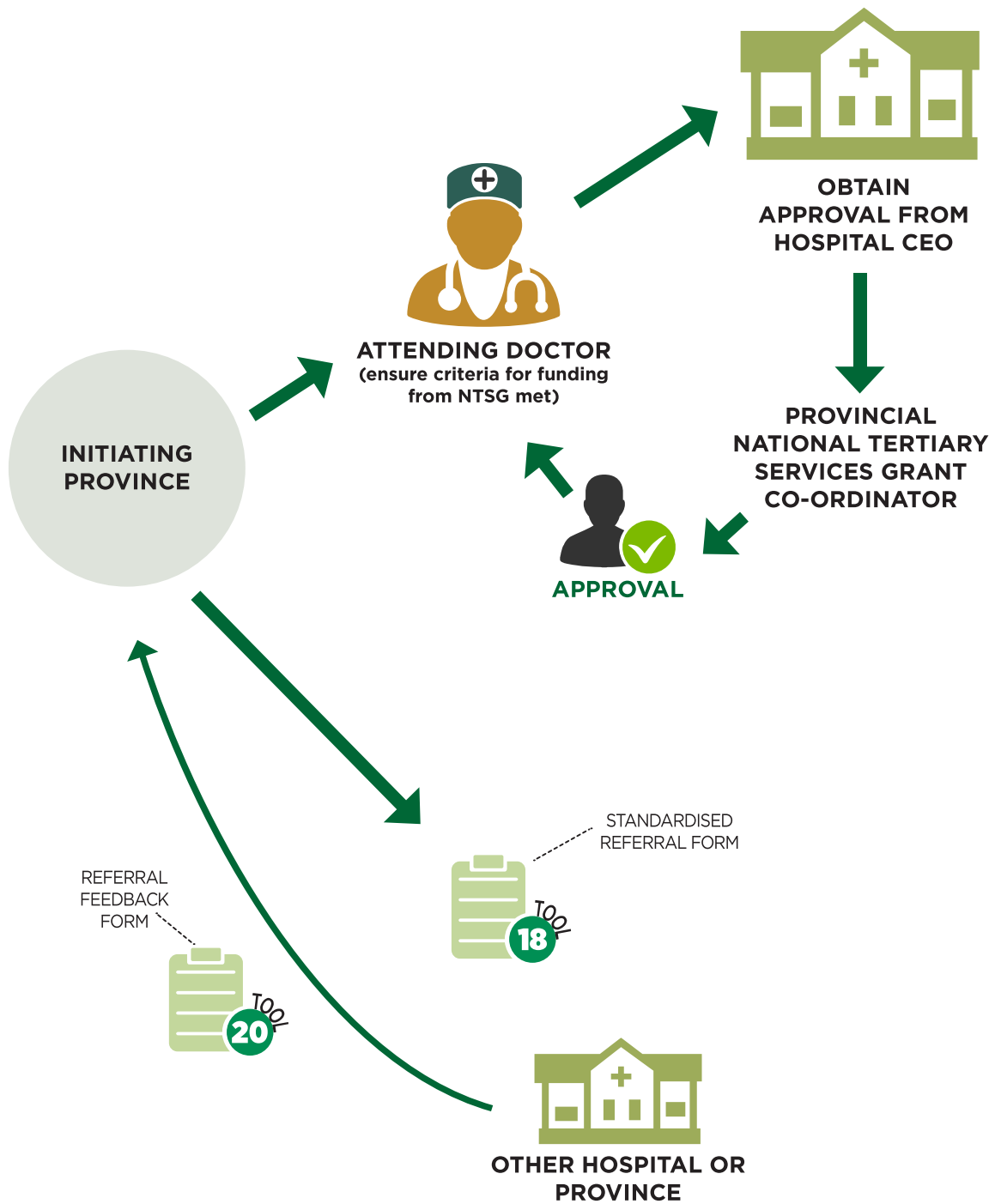


Figure 8: Inter-provincial referral process

Referring Province

- The clinical practitioner must ensure that the criteria for referral complies with the National Tertiary Services Grant (NTSG) clinical formulary/protocols.
- The treating/referring clinical practitioner must ensure that the requested treatment required is covered by the defined NTSG “Yes List”.
- Formal approval is to be requested from the hospital's medical superintendent or delegated clinical practitioner to the delegated provincial NTSG for up referral.
- The NTSG coordinator must confirm in writing that the treatment required is/is not funded by the NTSG.
- Approval will be granted by the delegated provincial NTSG subject to the treating hospital confirming the criteria and funding, for referral for specialised services.

Treating/Receiving Province/Hospital

The NTSG provincial coordinator will grant formal approval:

- If the treatment complies with the clinical formulary/protocols.
- If funds are available.
- And may cap the funding amount based on evidence based medicine benchmarking (invoice pro-forma).

The receiving clinician must ensure that:

- Proper consultation between the referring and treating clinical practitioners has been effected.
- He/she has been adequately informed of the required, requested treatment and that all specialised diagnostic and investigative results have been submitted to the treating doctor.

A patient residing in another province that is self-referred will be assessed accordingly, based on emergency, need and demand.

Down Referrals

CONTINUED MANAGEMENT

- A client may be down referred to the originating health establishment or another receiving health establishment for further treatment, recuperation or rehabilitation after the necessary consultation/treatment has taken place at a higher level of care.
- In other cases, a client who is clinically stable or requires home based care or health promotion and does not need to make repeated visits to the referral health establishment may be referred to the initiating health establishment or another appropriate lower level health establishment to access the required care.
- Down referrals to the initiating health establishment or another appropriate level of health establishment may take place from a central, tertiary, regional or district hospital.
- In cases where a client moves to a different location, they may be referred to a health establishment at the same level of care e.g. from one tertiary hospital to another.
- All clients who are referred from one health establishment to another must receive the standardised referral form (Tool 20) that provides sufficient information for the receiving health establishment to continue care with a copy being submitted to the original referring doctor, health establishment or community health service.

GENERAL PRINCIPLES

Scenarios for the Supply of Medicine

- There are three main scenarios with regard to the supply of medicine required by a client who is down referred.
- The client may be referred either to a receiving health establishment where his/her medicine is available on the general formulary of the health establishment or he/she may be referred to a health establishment where the medicine needed is not on the general formulary. Special arrangements must be made to enable the client to obtain the medicines needed.
- In the third scenario (where the client continues to receive care at a higher level of care) the referring health establishment continues to supply the medicine required by the patient, with the medicine being sent to the receiving health establishment.

SCENARIO 1 Medicine available on the general formulary of the receiving health establishment

- A prescription is written at the referring health establishment (Tool 26). The prescription may include five repeats and remains valid until it expires.
- Where an appropriate prescriber is present at the receiving health establishment he/she may prescribe the medicine required.
- Where there is not an appropriate prescriber at the receiving health establishment, the prescription for six months written at the referring health establishment, may be dispensed at the receiving health establishment.
- If the medicine is on the general formulary of the dispensing health establishment, that health establishment will carry the cost of the medicine.
- If the medicine prescribed is on the formulary of a tertiary hospital, the cost of the medicine can be recovered from the NTSG.

SCENARIO 2 Medicine is NOT available on the general formulary of the receiving health establishment

- The client must be encouraged to visit the receiving health establishment within one week of receiving the down referral form.
- If the medicine required is not on the formulary of the receiving health establishment but an appropriate prescriber is available, the receiving health establishment must make arrangements for access to the medicine on an individual access basis.
- In the case of a hospital or community health centre, the responsible pharmacist of the receiving health establishment must submit an individual client application within one week of the patient visiting the receiving health establishment to the pharmaceutical and therapeutics committee (PTC) of that health establishment or other mandated PTC.
- In cases where the client is down referred to a primary healthcare clinic, the down referral form must be submitted to the district pharmacist, who will submit an individual client application to the district PTC or other mandated PTC.
- The relevant PTC must assess the individual client application within one week and respond to the responsible pharmacist or the district pharmacist (as applicable).
- Once permission has been obtained from the PTC, the medicine needed is added to the formulary of the receiving health establishment for **individual patient use only**, and an order is placed with the relevant provincial medicine procurement unit (PMPU)
- The cost of the medicine is allocated to the NTSG, applicable conditional grant or the district health services budget as applicable.
- The cost of the repeat supplies of medicines dispensed at the receiving health establishment is the responsibility of the health facility and district in which the client resides. The cost of higher level (prescriber level 3, 4, and 5) medicines should be debited to the district/provincial objective created for this purpose.
- The district will be responsible for monitoring and auditing the prescribing of referral medicines and the cost debited to this objective.

SCENARIO 3 Medicine is NOT available on the general formulary of the receiving health establishment and continues to be supplied by the referring health establishment

- If the medicine is not on the general formulary of the receiving health establishment, and it is not possible for the medicine needed to be added to the formulary of the receiving health establishment on an individual client basis, it may continue to be prescribed and dispensed at the referring health establishment.
- The patient medicine parcel is sent by the referring health establishment to the receiving health establishment for collection by the patient
- Cost will then be carried by the referring health establishment.
- If the medicine does not qualify for payment from the NTSG, the cost will be covered either by the applicable conditional grant or by the district health services budget.

Inter Provincial Medication Movement

In provinces where there is no tertiary or central hospital services and medicine prescribed is not on the provincial formulary, Special arrangements must be made to enable the client to obtain the medicines needed

The cost of the medicine must be carried by the province where the receiving facility is located.

1. First month's supply (of all medicines on the prescription) to be dispensed by the pharmacy at the tertiary and central hospitals.
2. Scenario 2 listed above could be applied or the module on Rx solution programme be activated.
3. This will then allow the medication to be ordered via the CCMD programme and the medication will then be available at the dispensing point.

The medication cost will then be debited to the relevant province.

TOOL 22

Standardised Prescription Format



health

Department:
Health
REPUBLIC OF SOUTH AFRICA

PRESCRIBER NAME												
Qualification												
Practitioner No: (eg HPCSA/SANC)												
Referring practitioner												
Address of prescribing institution												
Tel no./e-mail												
PATIENT DETAILS												
First name					Surname							
Address												
					Postal code							
Date of birth					Y	Y	Y	Y	M		Age	
Contact number											Gender	
Identity number											Weight	
Patient file/record number												
Diagnosis and ICD10 code/s												
List of patient allergies												
PATIENT PRESCRIPTION												
Name of medication (INN)	Dosage, dosage form, frequency, duration, route of administration, quantity to be dispensed*	No. of repeats	Dispensing	First Issue	Repeat Issue 2 of 6	Repeat Issue 3 of 6	Repeat Issue 4 of 6	Repeat Issue 5 of 6	Repeat Issue 6 of 6			
			Quantity									
			Date									
			Name									
			Signature									
PRESCRIBERS NOTES												
*For S6, quantity to be dispensed to be written in numbers and words												
Prescriber's signature:					Date							
					Y	Y	Y	Y	M	M	D	D

Chronic Medicine Collection Programme

- A client who is clinically stable, and does not require monthly attendance at a hospital or clinic and can be managed in the community, may be referred to a chronic medicine collection programme (such as the CCMDD or CDU), an adherence club (if available) or WBPHCOTs.
- The client must comply with the relevant eligibility criteria prior to being enrolled on one of the programmes mentioned above.
- The referral must be done using the appropriate stationary and completion of the administrative procedures as defined in the applicable guidelines.
- If the client is placed on a chronic medicine collection programme, the dispensing, collection and cost of the medicines will be handled in accordance with the relevant chronic medicine collection programme.

NOTE Collection of medicines using the chronic medicine collection programme is not a down referral.

- The patient should be enrolled on the CCMDD programme (**Tool 23**)
- **Tool 24** provides the SOP for CCMDD referral enrollment



Health Facility CCMDD Patient Enrollment Record

Province: _____

District: _____

Name of health facility: _____

New/Rpt (N/R)	Patient surname	Patient first name	Patient facility file no.	Patient ID No	ART/chronic patient (A/C)	Date of new script	Next scheduled date for collection	Prescription renewal date (six month clinical review date)	Selected Pick-up point for collection


**TOOL
24**

Standard Operating Procedure for Patient Referral to the CCMDD Programme

TITLE	STANDARD OPERATING PROCEDURE FOR ENROLMENT OF PATIENTS IN THE CCMDD PROGRAMME		
INSTITUTION	National Department of Health		
REFERENCE NUMBER	CCMDD SOP-2	EFFECTIVE DATE	Feb 2014
PURPOSE			
The purpose of this document is to outline the process with which patients are identified and registered onto the Central Chronic Medicine Dispensing and Distribution (CCMDD) programme.			
PERSONS AFFECTED			
PDoH Facility verification person (pharmacist/PA/nurse) PDoH Prescriber (doctor/nurse) CCMDD service provider agent			
APPLICABLE POLICIES/LEGISLATION			
Medicines and Related Substances Act 101 of 1965 as amended, and the regulations and guidelines published in terms of this Act (the 'Medicines Act') Pharmacy Act 53 of 1974 as amended, and the regulations and rules published in terms of this Act (the 'Pharmacy Act') National Health Act 61 of 2003 as amended, and regulations issued in terms of the Act			
ABBREVIATIONS			
CCMDD: Central Chronic Medicine Distribution and Dispensing CCMDD service provider: Dispensing service provider NDoH: National Department of Health PDoH: Provincial Department of Health ART: Antiretroviral therapy			
NOTES/SAFETY WARNINGS			
A list of authorised prescribers must be maintained by PDoH health facility, district and province. PDoH/district must submit a copy of this list per health facility to CCMDD service provider Facility must ensure that only prescriptions signed by an authorised prescriber are submitted to the CCMDD service provider			
NO	PROCEDURE	RESPONSIBILITY	
1	<p>Identify stable adult ART patients eligible for enrollment onto the CCMDD programme:</p> <p>Patient must meet the following criteria:</p> <ul style="list-style-type: none"> a) On the same treatment regimen for at least 12 months b) Most recent two laboratory results normal: <ul style="list-style-type: none"> • Most recent VL taken in past six months, thus a minimum of 12 months on HAART • 2 consecutive viral loads undetectable • 2 consecutive fasting plasma glucose (FPG) normal for diabetes and • 2 consecutive blood pressure (BP) normal for hypertension c) Assess whether the patient is stable according to specific disease management protocols. d) Clinician confirms patient's eligibility for CCMDD programme e.g. stable and adherent to therapy e) Patient voluntary agrees to registration onto CCMDD programme f) No current TB and No medical condition requiring regular clinical consultations g) Patients requiring adherence support can still continue if they want to h) Chronic medicine items prescribed must on the provincial CCMDD medicine list 	<p>Authorised prescriber</p>	

2	<p>Inform the patient about the CCMDD programme and write a valid prescription:</p> <ol style="list-style-type: none"> Explain how the programme works and ask the patient if he/she is willing to participate. Write a new prescription on the official CCMDD prescription and consent form which is repeatable for six (6) months – include all chronic medication on one form. Issue the first supply of medicines (Month 1) to the patient OR inform patient to collect from the health facility dispensary (as applicable). Note: Issue 2 month supply of medicines (Month 1 and 2) if patient is put on a double supply cycle. Inform the patients of repeat collection dates for the remaining 5 months of cycle, blood date (if applicable) and next clinical review (return) date. Write dates on medicine collection card and on the CCMDD prescription and consent form as well. (Note for double supply the NEXT SCHEDULE DATE should be 56 days from script date and patient will only have 2 collections dates in the cycle, after which they will need to return for clinical review). 	<p>Authorised Prescriber</p>
3.	<p>Obtain patient consent and select pick-up point:</p> <ol style="list-style-type: none"> Patient must agree to participate in CCMDD programme before enrolment. Inform the patient of the list of pick-up points available for collection of medicines (internal and external pick-up points that are available to facility). Give the patient information on the selected pick-up point and ensure that patient knows the address and operational times. Advise the patient of the process and identification requirements to collect repeat medicines from the pick-up point. (ID document to be presented at PuP). Give the patient a CCMDD medicine collection card with the patient details, PUP name, the scheduled collection dates, blood date (if applicable) and the next clinic appointment/review date. 	<p>Prescriber/ designated health facility person/ Ppharmacy</p>
4.	<p>Verify CCMDD prescription and consent form for completeness:</p> <ol style="list-style-type: none"> Check whether the prescription complies with legislative provisions and standard treatment guidelines: <ul style="list-style-type: none"> Correct date Name, ID and other details of the patient Signature by authorised prescriber Diagnosis, generic name of medicine, dosage form, quantity, strength and directions for use Adherence to CCMDD medicine list Selected PUP Patient consent signature Inform the prescriber of changes required to prescription (if applicable) Sign to confirm that prescription has been verified and retain original prescription in the patient health facility file (folder). 	<p>Verification person (pharmacist/PA/nurse)</p>
5.	<p>Submit CCMDD prescription and consent form to the service provider:</p> <ol style="list-style-type: none"> Transmit the CCMDD prescription and consent form to the CCMDD service provider electronically or by other suitable method. CCMDD prescriptions must be transmitted at least once a week by the CCMDD service provider. 	<p>CCMDD service provider agent</p>
6.	<p>Maintenance of records: Record number of patients:</p> <ul style="list-style-type: none"> enrolled on the programme utilising the different types of PUPs i.e. internal, outreach and external. 	<p>Designated health facility person (data capturer/PA/champion)</p>
7.	<p>Updating of patient information: Inform the patient that they should contact the CCMDD service provider using the toll-free number of any change in personal information e.g. cell number</p>	<p>Health facility/patient</p>
<p>CHECKLIST/TOOLS</p>		<p>✓ if available</p>
	<ol style="list-style-type: none"> List of authorised prescribers Standardised CCMDD prescription and consent form (province to provide) Provincial CCMDD medicine list (province to provide) Health facility patient enrolment record 	<ol style="list-style-type: none">

Referral to Adherence Clubs

- Clinicians are required to assess a patient's eligibility for clubs and, if a patient meets the requirements, refer them to the appropriate person in the facility responsible for booking the patients into new clubs.
- Clinicians can support club set-up in the faculty by discussing the idea with patients who meet the criteria.
- Each facility has a different approach to booking and allocating patients to a club during the recruitment process i.e. before the first club session.
- A facility has to determine the staff member responsible for this process depending on their daily availability for managing this process.
- The patient will be referred to the appropriate booking person who then requires an appropriate tool to allocate the patient to the club to monitor when the club is full (Tool 25).
- The patient information will be entered into the ART adherence club register (**Tool 6**).

CHRONIC MEDICINE COLLECTION PROGRAMME


A client who is clinically stable, and does not require monthly attendance at a hospital or clinic and can be managed in the community, may be referred to a chronic medicine collection programme (such as the CCMDD or CDU), an adherence club (if available) or WBPHCOTs. The client must comply with the relevant eligibility criteria prior to being enrolled on one of the programmes mentioned above. The referral must be done using the appropriate stationary and completion of the administrative procedures as defined in the applicable guidelines. If the client is placed on a chronic medicine collection programme, the dispensing, collection and cost of the medicines will be handled in accordance with the relevant chronic medicine collection programme.

**TOOL
25**

Booking system for Adherence Club


NAME OF CLUB FACILITATOR					
LOCATION OF CLUB					
DATE OF FIRST CLUB VISIT					
CALENDAR DAY					
NO	PATIENT FILE NUMBER	SURNAME & INITIALS OF PATIENT	DRUG REGIMEN	FILE RETRIEVED (Y/N)	PATIENT ENTERED INTO REGISTER
1					
2					
3					
4					
5					
6					
7					
8					
9					
10					
11					
12					
13					
14					
15					
16					
17					
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20					
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22					
23					
24					
25					
26					
27					
28					
29					
30					

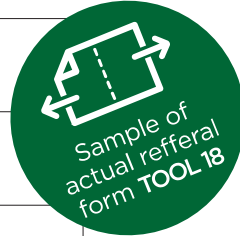
Standardised Patient Referral Form (Keep on record)

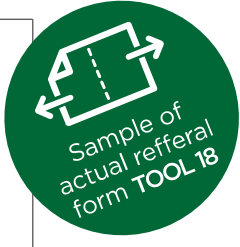
 health Department of Health REPUBLIC OF SOUTH AFRICA		<input type="checkbox"/> Outpatient		<input type="checkbox"/> Emergency		<input type="checkbox"/> Transfer	
PATIENT DETAILS							
First name				Surname			
Next of kin if patient is a minor - first name				Surname			
Address							
Postal code							
Date of birth	Y	Y	Y	M	M	D	D
Contact number							
Identity number (if available)							
Patient file/record number							
TO BE COMPLETED FOR EMERGENCY REFERRALS/TRANSFERS							
INSTITUTION NAME							
Classification of facility	District hospital	Specialised TB hospital	Regional hospital	Specialised mental hospital	Tertiary hospital	Central hospital	
Department referred to							
Receiving doctors name							
Time patient accepted							
Time transport booked for patient							
CLINICAL INFORMATION ON PATIENT							
CURRENT MEDICAL HISTORY							
RELEVANT PAST HISTORY							
VITAL SIGNS: (RELEVANT DATA ONLY)	Blood pressure	Weight	Temp.	Pulse	HB	Resp.	GCS
HIV INFORMATION	Viral load	CD4					HGT
TB INFORMATION	Chest X-ray	GeneXpert					
	Sputum One	Date	Results	Sputum Two	Date	Results	



Standardised Patient Referral Form (Patient to take)

 health Department of Health REPUBLIC OF SOUTH AFRICA		<input type="checkbox"/> Outpatient		<input type="checkbox"/> Emergency		<input type="checkbox"/> Transfer	
PATIENT DETAILS							
First Name				Surname			
Next of kin if patient is a minor - first name:				Surname			
Address							
Postal code							
Date of birth	Y	Y	Y	M	M	D	D
Contact number							
Identity number (if available)							
Patient file/record number							
TO BE COMPLETED FOR EMERGENCY REFERRALS/TRANSFERS							
INSTITUTION NAME							
Classification of facility	District hospital	Specialised TB hospital	Regional hospital	Specialised mental hospital	Tertiary hospital	Central hospital	
Department referred to							
Receiving doctors name							
Time patient accepted							
Time transport booked for patient							
CLINICAL INFORMATION ON PATIENT							
CURRENT MEDICAL HISTORY							
RELEVANT PAST HISTORY							
VITAL SIGNS: (RELEVANT DATA ONLY)	Blood pressure	Weight	Temp.	Pulse	HB	Resp.	GCS
HIV INFORMATION	Viral load	CD4					HGT
TB INFORMATION	Chest X-ray	GeneXpert					
	Sputum One	Date	Results	Sputum Two	Date	Results	





RELEVANT CLINICAL EXAMINATION FINDINGS							
DIAGNOSIS							
CATEGORY OF TB	New case <input type="checkbox"/>	Retreatment <input type="checkbox"/>	Smear negative <input type="checkbox"/>	Chronic- MDR <input type="checkbox"/>	Chronic- XDR <input type="checkbox"/>	XDR review <input type="checkbox"/>	
INVESTIGATIONS AND FINDINGS (ATTACH RESULTS)							
CURRENT MEDICATION AND TREATMENT GIVEN							
REASON FOR REFERRAL							
REFERRING INSTITUTION/CLINICIAN DETAILS							
Referring facility name							
Referring practitioner name							
Professional council registration number							
Date	Y	Y	Y	M	M	D	D
						Time:	
Signature							
Tel No./e-mail							

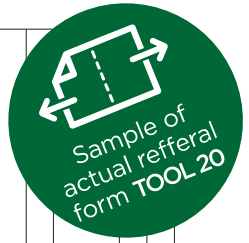
RELEVANT CLINICAL EXAMINATION FINDINGS							
DIAGNOSIS							
CATEGORY OF TB	New Case <input type="checkbox"/>	Retreatment <input type="checkbox"/>	Smear negative <input type="checkbox"/>	Chronic- MDR <input type="checkbox"/>	Chronic- XDR <input type="checkbox"/>	XDR review <input type="checkbox"/>	
INVESTIGATIONS AND FINDINGS (ATTACH RESULTS)							
CURRENT MEDICATION AND TREATMENT GIVEN							
REASON FOR REFERRAL							
REFERRING INSTITUTION/CLINICIAN DETAILS							
Referring facility name							
Referring practitioner name							
Professional council registration number							
Date	Y	Y	Y	M	M	D	D
						Time:	
Signature							
Tel no./e-mail							



Standardised Patient Referral Feedback Form (Keep on record)



STANDARDISED PATIENT REFERRAL FEEDBACK FORM																	
FEEDBACK TO:																	
Institution name																	
Department referred from																	
Referring practitioner																	
Appointment/referred date																	
Appointment reference number																	
Tel no./e-mail																	
PATIENT DETAILS																	
First name			Surname			Postal code											
Next of kin if patient is a minor - first name																	
Surname																	
Address																	
Date of birth		Y	Y	Y	Y	M	M	D	D	Age							
Contact number										Gender							
Identity number (if available)										Weight							
Patient file/record number																	
CLINICAL INFORMATION ON PATIENT																	
Brief history of presenting symptoms and initial diagnosis																	
Primary, secondary diagnosis and Co-morbidities at referral institutions																	
Investigations and findings (attach results)																	
Procedures performed and results thereof																	
Current medication and treatment prescribed																	
Details of ongoing management required																	
Yes		<input type="checkbox"/>	No		<input type="checkbox"/>	Submitted via		Date		Y	Y	Y	Y	M	M	D	D
Patient to be seen again at referral institution		Yes	<input type="checkbox"/>	No	<input type="checkbox"/>	Date of next appointment		Submitted via		Email	<input type="checkbox"/>	Fax	<input type="checkbox"/>	Hard copy		<input type="checkbox"/>	
FEEDBACK FROM (REFERRAL INSTITUTION)																	
Referring facility name																	
Referring practitioner (name)																	
Date		Y	Y	Y	Y	M	M	D	D	Time							
Signature																	
Professional council registration number																	
Tel no./e-mail																	



STANDARDISED PATIENT REFERRAL FEEDBACK FORM																	
FEEDBACK TO:																	
Institution name																	
Department referred from																	
Referring practitioner																	
Appointment/referred date																	
Appointment Reference number																	
Tel no./e-mail																	
PATIENT DETAILS																	
First name			Surname			Postal code											
Next of kin if patient is a minor - first name																	
Surname																	
Address																	
Date of birth		Y	Y	Y	Y	M	M	D	D	Age							
Contact number										Gender							
Identity number (if available)										Weight							
Patient file/record number																	
CLINICAL INFORMATION ON PATIENT																	
Brief history of presenting symptoms and initial diagnosis																	
Primary, secondary diagnosis and co-morbidities at referral institutions																	
Investigations and findings (attach results)																	
Procedures performed and results thereof																	
Current medication and treatment prescribed																	
Details of ongoing management required																	
Yes		<input type="checkbox"/>	No		<input type="checkbox"/>	Submitted via		Date		Y	Y	Y	Y	M	M	D	D
Patient to be seen again at Referral Institution		Yes	<input type="checkbox"/>	No	<input type="checkbox"/>	Date of next appointment		Submitted via		Email	<input type="checkbox"/>	Fax	<input type="checkbox"/>	Hard copy		<input type="checkbox"/>	
FEEDBACK FROM (REFERRAL INSTITUTION)																	
Referring facility name																	
Referring practitioner (name)																	
Date		Y	Y	Y	Y	M	M	D	D	Time							
Signature																	
Professional council registration number																	
Tel no./e-mail																	

Standardised Internal Patient Referral Form (Keep on record)



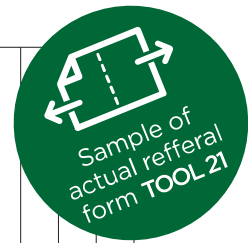
TYPE OF REFERRAL	Emergency <input type="checkbox"/>	Outpatient <input type="checkbox"/>	Transfer <input type="checkbox"/>
PATIENT DETAILS			
First name	Surname		
Next of kin if patient is a minor - first name	Surname		
Address			
Date of birth	Y Y Y Y M M D D	Age	Postal Code
Contact number		Gender	
Identity number (if available)		Weight	
Patient file/record number			
CLINICAL INFORMATION ON PATIENT			
Medical history			
Relevant past history			
Relevant clinical examination findings			
Summary of investigations and findings			
Diagnosis			
Current medication and treatment given			
Reason for referral			
TO BE COMPLETED FOR EMERGENCY REFERRALS/TRANSFERS			
CLINICIAN DETAILS			
Referring department			
Referring practitioner (name)			
Date	Y Y Y Y M M D D	Time:	
Signature			
Tel no./e-mail			
Professional council registration number			
Appointment date	Y Y Y Y M M D D		
Appointment made with			
Tel no./e-mail			



Standardised Internal Patient Referral Form (Patient to take)



TYPE OF REFERRAL	Emergency <input type="checkbox"/>	Outpatient <input type="checkbox"/>	Transfer <input type="checkbox"/>
PATIENT DETAILS			
First Name	Surname		
Next of kin if patient is a minor - first name	Surname		
Address			
Date of birth	Y Y Y Y M M D D	Age	Postal Code
Contact number		Gender	
Identity number (if available)		Weight	
Patient file/record number			
CLINICAL INFORMATION ON PATIENT			
Medical history			
Relevant past history			
Relevant clinical examination findings			
Summary of investigations and findings			
Diagnosis			
Current medication and treatment given			
Reason for referral			
TO BE COMPLETED FOR EMERGENCY REFERRALS/TRANSFERS			
CLINICIAN DETAILS			
Referring department			
Referring practitioner (name)			
Date	Y Y Y Y M M D D	Time	
Signature			
Tel no./e-mail			
Professional council registration number			
Appointment date	Y Y Y Y M M D D		
Appointment made with			
Tel no./e-mail			



C MONITORING

Monitoring is critical to assess the optimal functioning of the referral system and for the implementation of quality improvement interventions to address deficiencies identified. Data will need to be collected at each level of the health system and cascaded to the provincial and national departments of health and used for local decision making.

This section of the manual provides a list of indicators that are required to be measured at the different levels of the healthcare delivery platform and the reporting frequency for cascading the data.

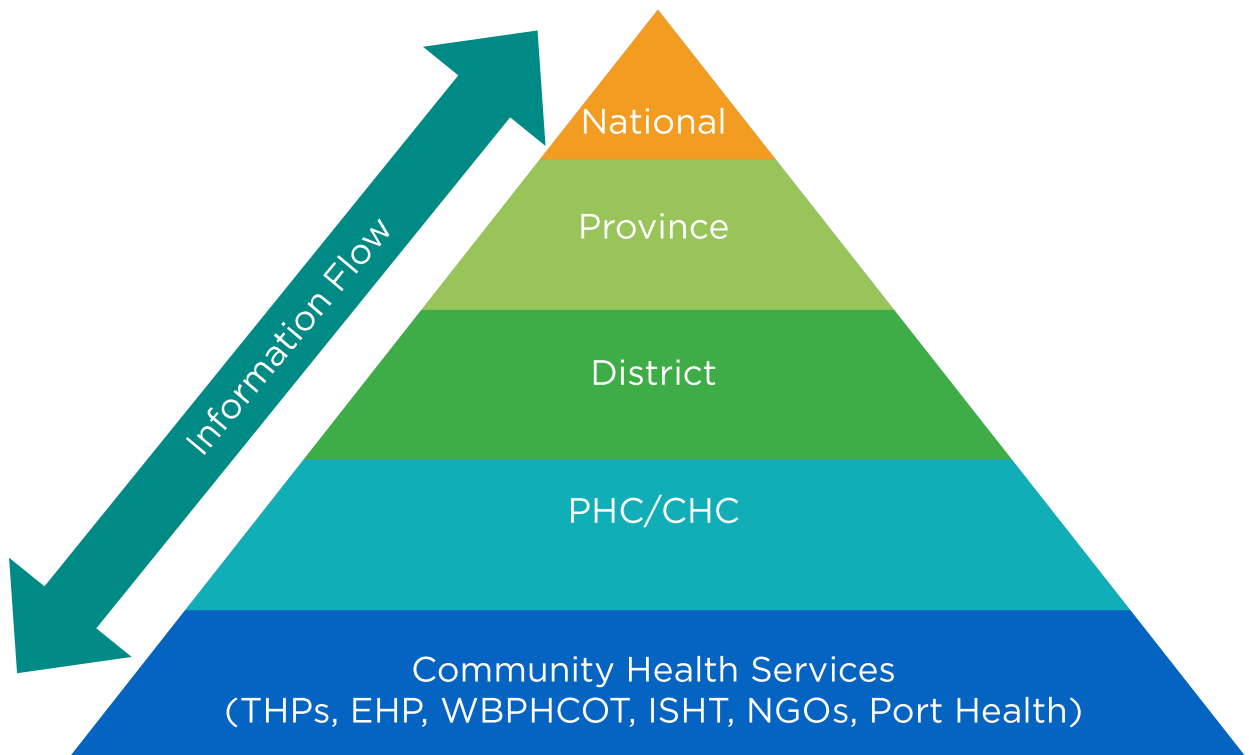


Figure 9 Data flow plan

OVERVIEW OF REFERRAL RATE INDICATORS AND THE LEVELS AT WHICH DATA IS COLLECTED

INDICATOR	Referral rate	Level at which data is to be collected
NUMERATOR	Number of patients referred from lower levels of care	Community Health Services; PHC; CHC; District, Regional, Tertiary; Central Hospitals
DENOMINATOR	Outpatient headcount	
FREQUENCY	Quarterly	
REPORT TO	District, province, national	
DATA SOURCE	Outpatient registers	
INDICATOR	Down referral rate	PHC; CHC; District, Regional, Tertiary; Central Hospitals
NUMERATOR	Number of patients down referred to lower level of care for continued management	
DENOMINATOR	Outpatient headcount	
FREQUENCY	Quarterly	
REPORT TO	District, province, national	
DATA SOURCE	Outpatient registers	Community Health Services; PHC; CHC; District, Regional, Tertiary; Central Hospitals
INDICATOR	Referral feedback rate	
NUMERATOR	Number of referrals in which feedback was received from the receiving referral facility	
DENOMINATOR	Total number of patients referred	
FREQUENCY	Quarterly	
REPORT TO	District, province, national	District, Regional, Tertiary; Central Hospitals
DATA SOURCE	Referral registers	
INDICATOR	Self-referral rate	
NUMERATOR	Number of attending hospitals without a referral	
DENOMINATOR	Total number of outpatient	
FREQUENCY	Quarterly	District, Regional, Tertiary; Central Hospitals
REPORT TO	District, province, national	
DATA SOURCE	Outpatient registers	

REFERRAL RATE INDICATORS

The following section describes the referral indicators that are to be analysed at each level of the health service based on the data required by each level for management decisions.

Community Health Services:

This data is to be collected by the CHW's

Community Health Services Referral Rate

NUMERATOR	Number of referrals received from community health services
DENOMINATOR	Total number of community health services visits
FREQUENCY	Quarterly
REPORT TO	District, province, national
DATA SOURCE	CHW referral registers

Community Health Services Referral Feedback Rate

NUMERATOR	Number of referrals in which feedback was received from the PHC/CHC
DENOMINATOR	Total number of patients referred
FREQUENCY	Quarterly
REPORT TO	District, province, national
DATA SOURCE	CHW referral registers

Primary Healthcare Clinic/Community Healthcare Centre

This data is to be collected at the PHC/CHC from the outpatient registers and the referral register at the facility.

PHC/CHC Referral Rate

NUMERATOR	Number of referrals received from community health services (CHW; NGO;s environmental health; port health; correctional services)
DENOMINATOR	Outpatient headcount
FREQUENCY	Quarterly
REPORT TO	District, province, national
DATA SOURCE	Outpatient registers

PHC/CHC Down Referral Rate

NUMERATOR	Number of PHC patients down referred to community-based services, adherence clubs and CCMDD
DENOMINATOR	Outpatient headcount
FREQUENCY	Quarterly
REPORT TO	District, province, national
DATA SOURCE	Outpatient registers

PHC/CHC Referral Feedback Rate

NUMERATOR	Number of referrals in which feedback was received from the district hospital or higher level of care
DENOMINATOR	Total number of patients referred
FREQUENCY	Quarterly
REPORT TO	District, province, national
DATA SOURCE	Referral registers

District Hospital

This data is to be collected from the outpatient and referral registers at the district hospital and analysed by the relevant facilities.

District Hospital Referral Rate

NUMERATOR	Number of patients referred from lower levels of care to district hospitals
DENOMINATOR	Outpatient headcount at district hospital
FREQUENCY	Quarterly
REPORT TO	District, province, national
DATA SOURCE	Outpatient registers

District Hospital down Referral Rate

NUMERATOR	Number of patients down referred to lower level of care for continued management (PHC/CHC/CCMDD/adherence clubs)
DENOMINATOR	Outpatient headcount at district hospital
FREQUENCY	Quarterly
REPORT TO	District, province, national
DATA SOURCE	Outpatient registers

District Hospital Self-Referral Rate

NUMERATOR	Number of attending district hospitals without a referral
DENOMINATOR	Total number of outpatient seen in district
FREQUENCY	Quarterly
REPORT TO	District, province, national
DATA SOURCE	Outpatient registers

District Hospital Referral Feedback Rate

NUMERATOR	Number of referrals in which feedback was received from higher levels of care (Regional/tertiary/specilaised hospitals)
DENOMINATOR	Total number of patients referred
FREQUENCY	Quarterly
REPORT TO	District, province, national
DATA SOURCE	Referral registers

Regional Hospital

This data is to be collected from the outpatient and referral registers at the regional hospital and analysed by the relevant facilities.

Regional Hospital Referral Rate

NUMERATOR	Number of patients referred from lower levels of care to regional hospitals
DENOMINATOR	Total number of outpatient seen in the regional hospital
FREQUENCY	Quarterly
REPORT TO	District, province, national
DATA SOURCE	Outpatient registers

Regional Hospital Down Referral Rate

NUMERATOR	Number of patients down referred to the district hospital for continued management
DENOMINATOR	Total number of outpatient seen
FREQUENCY	Quarterly
REPORT TO	District, province, national
DATA SOURCE	Outpatient registers

Regional Hospital Self-Referral Rate

NUMERATOR	Number of attending regional hospitals without a referral from a district hospital
DENOMINATOR	Total number of outpatient seen in the regional hospital
FREQUENCY	Quarterly
REPORT TO	District, province, national
DATA SOURCE	Outpatient registers

Regional Hospital Referral Feedback Rate

NUMERATOR	Number of referrals in which feedback was received from the tertiary facility
DENOMINATOR	Total number of patients referred
FREQUENCY	Quarterly
REPORT TO	District, province, national
DATA SOURCE	Referral registers

Tertiary Hospital

This data is to be collected from the outpatient and referral registers at the regional hospital and analysed by the relevant facilities.

Tertiary Hospital Referral Rate

NUMERATOR	Number of patients referred from lower levels of care to tertiary hospitals
DENOMINATOR	Total number of outpatient seen in the tertiary hospital
FREQUENCY	Quarterly
REPORT TO	District, province, national
DATA SOURCE	Outpatient registers

Tertiary Hospital down Referral Rate

NUMERATOR	Number of patients down referred to the regional/district hospital for continued management
DENOMINATOR	Total number of outpatient visits
FREQUENCY	Quarterly
REPORT TO	District, province, national
DATA SOURCE	Outpatient registers

Tertiary Hospital Self-Referral Rate

NUMERATOR	Number of attending tertiary hospitals without a referral from a district/regional hospital
DENOMINATOR	Total number of outpatient visits in the tertiary hospital
FREQUENCY	Quarterly
REPORT TO	District, province, national
DATA SOURCE	Outpatient registers

DISTRICT LEVEL

The following data should be analysed by the district on a quarterly basis. Quality improvement interventions should be developed.

District Community Health Services Referral Rate

NUMERATOR	Sum of all referrals received from community health services
DENOMINATOR	Total number of community health services visits
FREQUENCY	Quarterly
REPORT TO	District, province, national
DATA SOURCE	Facility

District Community Health Services Referral Feedback Rate

NUMERATOR	Sum of all referrals in which feedback was received from the receiving facility
DENOMINATOR	Total number of patients referred
FREQUENCY	Quarterly
REPORT TO	District, province, national
DATA SOURCE	Facility

District PHC/CHC Referral Rate

NUMERATOR	Sum of all referrals received from community health services
DENOMINATOR	Total number of outpatient headcount
FREQUENCY	Quarterly
REPORT TO	District, province, national
DATA SOURCE	Facility

District PHC/CHC down Referral Rate

NUMERATOR	Sum of all PHC patients down referred to community based services, adherence clubs and CCMDD
DENOMINATOR	Total number of outpatient headcount
FREQUENCY	Quarterly
REPORT TO	District, province, national
DATA SOURCE	Facility

District PHC/CHC Feedback Rate

NUMERATOR	Sum of all referrals in which feedback was received from the receiving facility
DENOMINATOR	Total number of patients referred
FREQUENCY	Quarterly
REPORT TO	District, province, national
DATA SOURCE	Facility

District Hospital Referral Rate

NUMERATOR	Sum of all referrals referred from lower levels of care to district hospitals
DENOMINATOR	Sum of total number of outpatient headcount in district hospitals
FREQUENCY	Quarterly
REPORT TO	District, province, national
DATA SOURCE	Facility

District Hospital down Referral Rate

NUMERATOR	Sum of all down referred to lower level of care for continued management (PHC/CHC/CCMDD/adherence clubs)
DENOMINATOR	Total number of outpatient headcount
FREQUENCY	Quarterly
REPORT TO	District, province, national
DATA SOURCE	Facility

District Client Referral Rate

NUMERATOR	Number of referrals across all facilities
DENOMINATOR	Total number of outpatient headcount across all facilities
FREQUENCY	Quarterly
REPORT TO	District, province, national
DATA SOURCE	Facilities

PROVINCIAL LEVEL

The following data should be analysed by the province for all districts on a quarterly basis.

Provincial Community Health Services Referral Rate

NUMERATOR	Sum of all district referrals received from community health services
DENOMINATOR	Total number of community health services visits
FREQUENCY	Quarterly
REPORT TO	District, province, national
DATA SOURCE	District

Provincial Community Health Services Feedback Rate

NUMERATOR	Sum of all district referrals in which feedback was received from the receiving facility
DENOMINATOR	Total number of patients referred
FREQUENCY	Quarterly
REPORT TO	District, province, national
DATA SOURCE	District

Provincial PHC/CHC Referral Rate

NUMERATOR	Sum of all district referrals received from community health services
DENOMINATOR	Total number of outpatient headcount
FREQUENCY	Quarterly
REPORT TO	District, province, national
DATA SOURCE	District

Provincial PHC/CHC down Referral Rate

NUMERATOR	Sum of all PHC patients down referred to community-based services, adherence clubs and CCMDD for each district
DENOMINATOR	Total number of outpatient headcount
FREQUENCY	Quarterly
REPORT TO	District, province, national
DATA SOURCE	District

Provincial PHC/CHC Feedback Rate

NUMERATOR	Sum of all district referrals in which feedback was received from the receiving facility
DENOMINATOR	Total number of patients referred
FREQUENCY	Quarterly
REPORT TO	District, province, national
DATA SOURCE	District

Provincial District Hospital Referral Rate

NUMERATOR	Sum of all district referrals referred from lower levels of care to district hospitals
DENOMINATOR	Sum of all Total number of outpatient headcount in district
FREQUENCY	Quarterly
REPORT TO	District, province, national
DATA SOURCE	District

Provincial District Hospital down Referral Rate

NUMERATOR	Sum of all districts hospitals down referred to lower level of care for continued management (PHC/CHC/CCMDD/adherence clubs)
DENOMINATOR	Total number of outpatient headcount
FREQUENCY	Quarterly
REPORT TO	District, province, national
DATA SOURCE	District

Provincial District Hospital Self-Referral Rate

NUMERATOR	Sum of all district's patients attending district hospitals without a referral
DENOMINATOR	Total number of outpatient headcount in district
FREQUENCY	Quarterly
REPORT TO	District, province, national
DATA SOURCE	District

Provincial Regional Hospital Referral Rate

NUMERATOR	Sum of all patients referred from lower levels of care to regional hospitals across the Province
DENOMINATOR	Total number of outpatient headcount in the regional hospital
FREQUENCY	Quarterly
REPORT TO	District, province, national
DATA SOURCE	Regional hospitals

Provincial Regional Hospital down Referral Rate

NUMERATOR	Sum of all patients down referred from all regional hospitals to the district hospital for continued management
DENOMINATOR	Total number of outpatient headcount
FREQUENCY	Quarterly
REPORT TO	District, province, national
DATA SOURCE	Regional

Provincial Regional Hospital Self-Referral Rate

NUMERATOR	Sum of all patients attending regional hospitals without a referral from a district hospital
DENOMINATOR	Total number of outpatient headcount in the regional hospital
FREQUENCY	Quarterly
REPORT TO	District, province, national
DATA SOURCE	Regional

Provincial Regional Hospital Feedback Rate

NUMERATOR	Sum of all referrals at regional hospitals in which feedback was received from the tertiary facility
DENOMINATOR	Total number of patients referred
FREQUENCY	Quarterly
REPORT TO	District, province, national
DATA SOURCE	Regional

Provincial Tertiary Hospital Referral Rate

NUMERATOR	Number of patients referred from lower levels of care to tertiary hospitals
DENOMINATOR	Total number of outpatient headcount in the tertiary hospital
FREQUENCY	Quarterly
REPORT TO	District, province, national
DATA SOURCE	Outpatient registers

Provincial Tertiary Hospital down Referral Rate

NUMERATOR	Number of patients down referred to the regional/district hospital for continued management
DENOMINATOR	Total number of outpatient headcount
FREQUENCY	Quarterly
REPORT TO	District, province, national
DATA SOURCE	Outpatient registers

Inter Provincial Referral Rate

NUMERATOR	Number of referrals from outside the province
DENOMINATOR	Total number of outpatient headcount in the tertiary hospital
FREQUENCY	Quarterly
REPORT TO	District, province, national
DATA SOURCE	Outpatient registers

Provincial Client Referral Rate

NUMERATOR	Number of referrals across all facilities
DENOMINATOR	Total number of outpatient headcount across all facilities
FREQUENCY	Quarterly
REPORT TO	District, province, national
DATA SOURCE	Districts

NATIONAL LEVEL

The following indicators should be analysed by the National Department of Health for all provinces

National Community Health Services Referral Rate

NUMERATOR	Sum of all provinces referrals received from community health services
DENOMINATOR	Total number of community health services visits for all provinces
FREQUENCY	Quarterly
REPORT TO	District, province, national
DATA SOURCE	Provinces

National Community Health Services Feedback Rate

NUMERATOR	Sum of all provincial referrals in which feedback was received from the receiving facility
DENOMINATOR	Total number of patients referred by CHW in each province
FREQUENCY	Quarterly
REPORT TO	District, province, national
DATA SOURCE	Province

National PHC/CHC Referral Rate

NUMERATOR	Sum of all provincial referrals received from community health services
DENOMINATOR	Total number of outpatient visits
FREQUENCY	Quarterly
REPORT TO	District, province, national
DATA SOURCE	Provinces

National PHC/CHC down Referral Rate

NUMERATOR	Sum of all PHC patients down referred to community-based services, adherence clubs and CCMDD for each Province
DENOMINATOR	Total number of outpatient headcount
FREQUENCY	Quarterly
REPORT TO	District, province, national
DATA SOURCE	District

National PHC/CHC Feedback Rate

NUMERATOR	Sum of all provincial referrals in which feedback was received from the receiving facility
DENOMINATOR	Total number of patients referred
FREQUENCY	Quarterly
REPORT TO	District, province, national
DATA SOURCE	Provinces

National District Hospital Referral Rate

NUMERATOR	Sum of all district referrals referred from lower levels of care to district hospitals across all Provinces
DENOMINATOR	Sum of All Total number of outpatient headcount in district
FREQUENCY	Quarterly
REPORT TO	District, province, national
DATA SOURCE	Provinces

National District Hospital down Referral Rate

NUMERATOR	Sum of all districts hospitals down referred to lower level of care for continued management (PHC/CHC/CCMDD/adherence clubs) across all provinces
DENOMINATOR	Total number of outpatient headcount
FREQUENCY	Quarterly
REPORT TO	District, province, national
DATA SOURCE	Provinces

National District Hospital Self-Referral Rate

NUMERATOR	Sum of all districts patients attending district hospitals without a referral across all Provinces
DENOMINATOR	Total number of outpatient headcount in district
FREQUENCY	Quarterly
REPORT TO	District, province, national
DATA SOURCE	Provinces

National Regional Hospital Referral Rate

NUMERATOR	Sum of all patients referred from lower levels of care to regional hospitals across all Province
DENOMINATOR	Total number of outpatient visits in the regional hospital
FREQUENCY	Quarterly
REPORT TO	District, province, national
DATA SOURCE	Provinces

National Regional Hospital down Referral Rate

NUMERATOR	Sum of all patients down referred from all Regional hospitals to the district hospital for continued management across all Provinces
DENOMINATOR	Total number of outpatient headcount
FREQUENCY	Quarterly
REPORT TO	District, province, national
DATA SOURCE	Provinces

National Regional Hospital Self-Referral Rate

NUMERATOR	Sum of all patients attending regional hospitals without a referral from a district hospital across all provinces
DENOMINATOR	Total number of outpatient headcount in the regional hospital
FREQUENCY	Quarterly
REPORT TO	District, province, national
DATA SOURCE	Provinces

National Regional Hospital Feedback Rate

NUMERATOR	Sum of all referrals at regional hospitals in which feedback was received from the tertiary facility across all provinces
DENOMINATOR	Total number of patients referred
FREQUENCY	Quarterly
REPORT TO	District, province, national
DATA SOURCE	Provinces

National Tertiary Hospital Referral Rate

NUMERATOR	Number of patients referred from lower levels of care to tertiary hospitals
DENOMINATOR	Total number of outpatient headcount in the tertiary hospital
FREQUENCY	Quarterly
REPORT TO	District, province, national
DATA SOURCE	Provinces

National Tertiary Hospital down Referral Rate

NUMERATOR	Number of patients down referred to the regional/district hospital for continued management
DENOMINATOR	Total number of outpatient headcount
FREQUENCY	Quarterly
REPORT TO	District, province, national
DATA SOURCE	National

Inter Provincial Referral Rate

NUMERATOR	Sum of all referrals from outside the province
DENOMINATOR	Total number of outpatient headcount in the tertiary hospital
FREQUENCY	Quarterly
REPORT TO	District, province, national
DATA SOURCE	Provinces

National Client Referral Rate

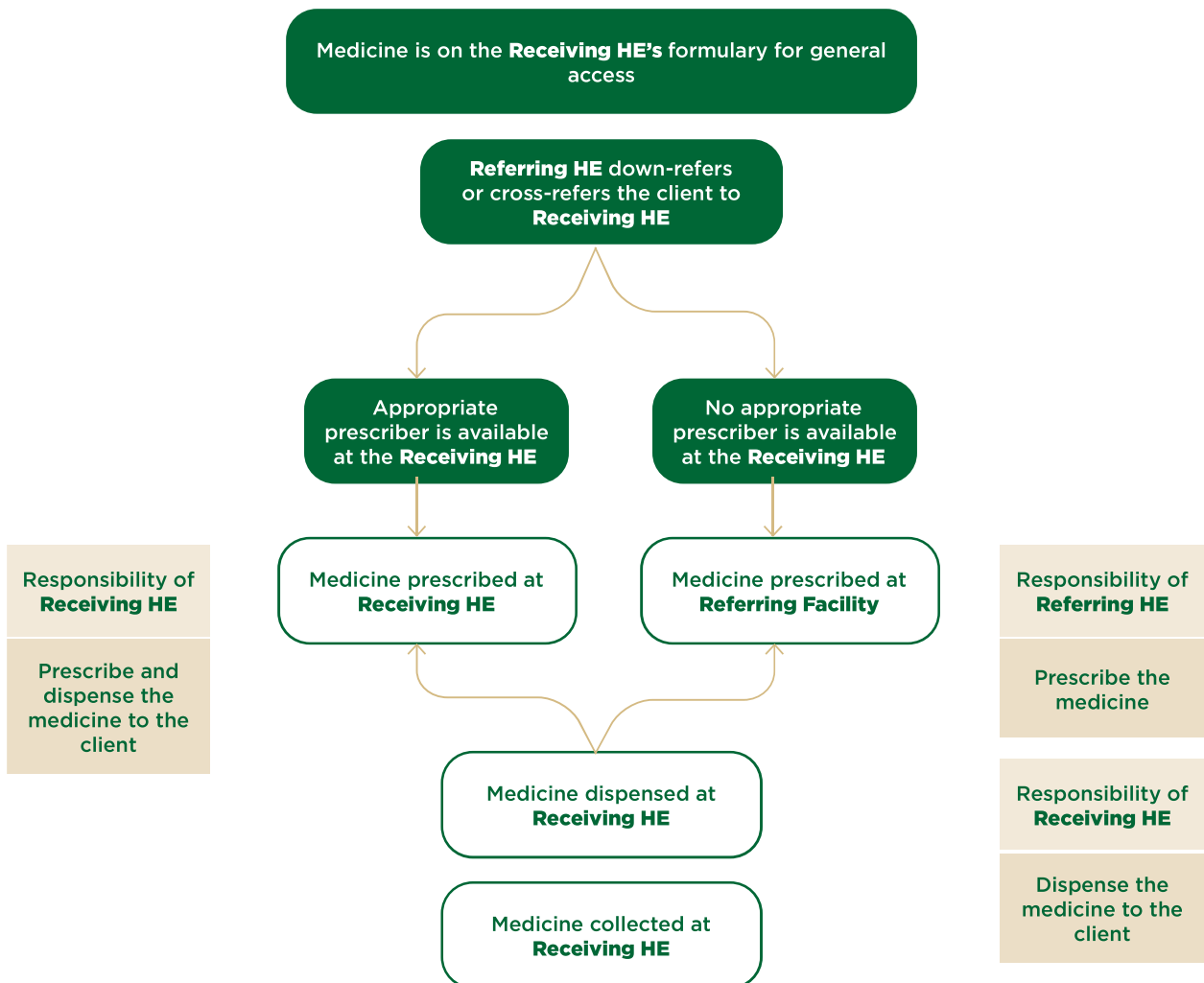
NUMERATOR	Number of referrals across all facilities
DENOMINATOR	Total number of outpatient headcount across all facilities
FREQUENCY	Quarterly
REPORT TO	District, province, national
DATA SOURCE	Provinces

REFERENCES

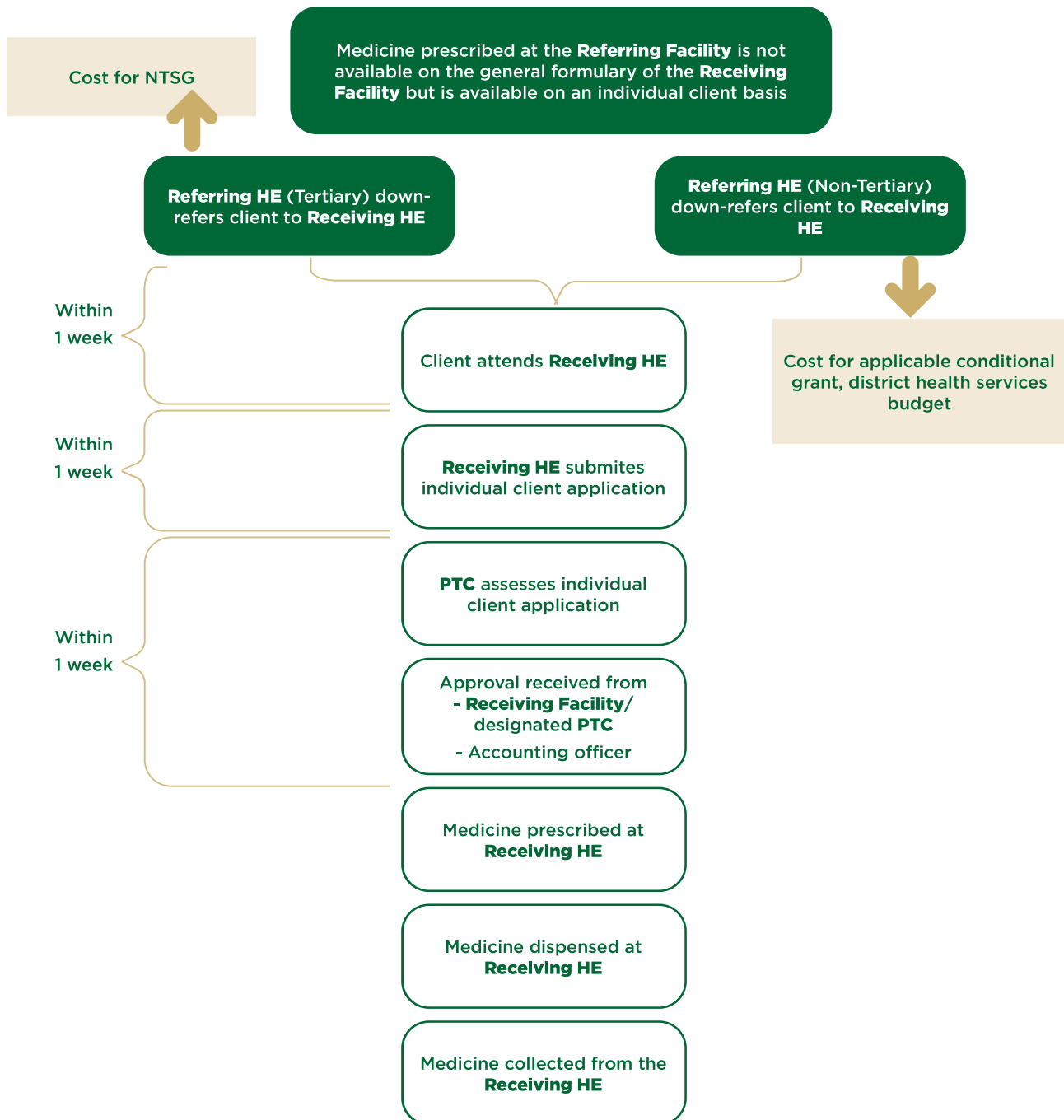
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APPENDIX MEDICINES MOVEMENT FLOW CHART

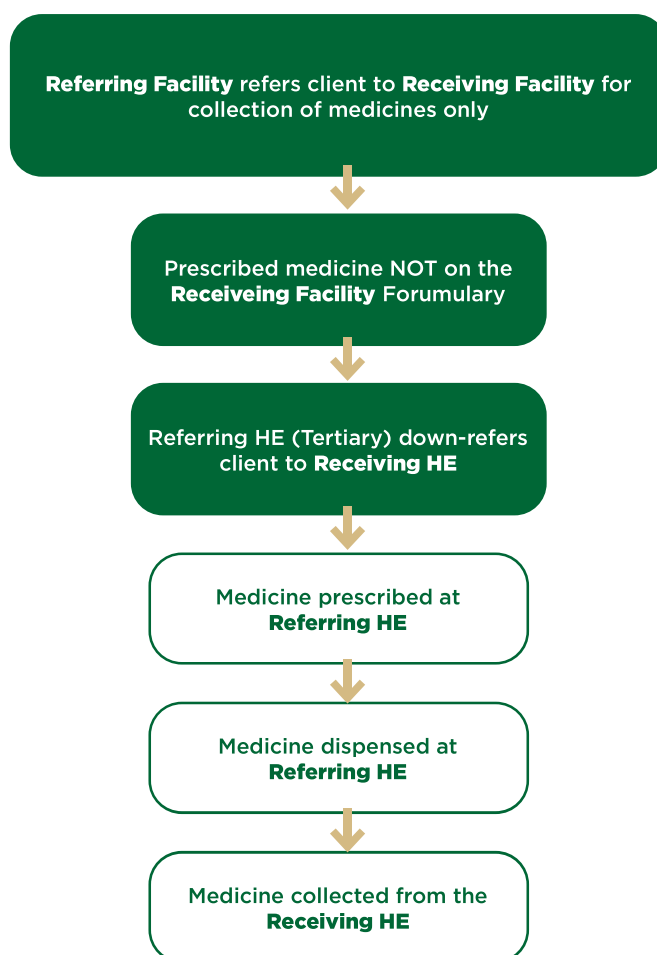
DOWN REFERRAL MEDICINE FLOWCHARTS



Other responsibilities		
Referring facility	Receiving facility	Client
Dispense at least one month's (28 days') supply of medicine prior to down referral.	Carry the cost of the medicine.	Bring any medicine that they are currently taking with the referral form to the receiving HE.
Instruct the client to take any medicine and referral forms to the receiving HE.		Attend the receiving facility regularly for check-ups and medicine collection.



Responsibilities			
Referring facility	Receiving Facility	PTC	Client
Dispense at least one month's (28 days') supply of medicine prior to down referral.	Prescribe and dispense the medicine to the client.	Review application within one week and approve access to the medicine on an individual client basis.	Bring any medicine that they are currently taking with the referral form to the receiving HE.
Instruct the client to take any medicine and referral forms to the receiving HE.	Allocate cost to the NTSG applicable conditional grant or district health services budget as relevant.		Visit the receiving HE within one week to for medicine on an individual (named) client basis.
Include instructions in the referral letter for the receiving HE to arrange medicine on an individual (named) client basis as soon as possible.	Send application to the relevant PTC within one week for approval of access to the medicine on an individual client basis.		Attend the receiving facility regularly for check-ups and medicine collection.



Other responsibilities		
Referring facility	Receiving facility	Client
Prescribe and dispense the medicine.	To record when the client collects the medicine and to inform the referring facility if the medicine remains uncollected.	Attend the receiving facility regularly for check-ups and medicine collection.
Carry the cost of the medicine.		

DISCLAIMER

This publication was produced for review by the United States Agency for International Development. It was prepared by Dr Shaidah Asmall, Senior Technical Advisor, who provided overall conceptual and technical editorial guidance and Dr Ozayr Mahomed of the Discipline of Public Health Medicine at the University of KwaZulu-Natal. The contents expressed in this publication do not necessarily reflect the views of the United States Agency for International Development or the United States Government.



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