COLLEGE OF
PHYSICIANS & SURGEONS
OF NOVA SCOTIA

Suite 400-175 Western Parkway
Bedford, Nova Scotia
Canada B4B 0V1
Phone: (902) 422-5823
Toll-free: 1-877-282-7767
Fax: (902) 422-7476
www.cpsns.ns.ca

Professional Standards Regarding Referral and Consultation for Patients with a Family Physician

Preamble

This professional standard sets out the professional obligations of physicians when referring patients or seeing patients in consultation with a primary care physician or another provider.

The referral-consultation process requires an ongoing balance of shared care and responsibility between the referring and consulting physicians that may evolve as the patient's care progresses. Clear articulation of the expectations on both sides is critical to maintaining that balance.

Professional Standards

1. Professional communication between referring and consulting physicians must always serve the best interests of patients and should be respectful, collegial, collaborative and courteous.

2. Referring physicians must:

    a. Provide a consultation request in writing unless circumstances prevent, which includes:

        i. accurate contact information (including address and phone number), basic demographic information about the patient (such as gender and age) and the patient's Nova Scotia Health Card (MSI) number and/or insurance information;

        ii. the referring physician's contact information (including address, phone number, and/or pager number);

        iii. the specific clinical reasons for the consultation request, together with the referring physician's expectations of the consultation outcome (such as medical opinion only, treatment, transfer of care or shared care);

iv. a summary of pertinent medical history, examination findings, current medications (name and dosage used, including those on a PRN basis), known allergies, and the identification of other physicians currently involved in the patient's care, where appropriate;

b. Only refer a patient to one consultant at a time within a discipline for a specific problem;

c. Act upon a patient's request for referral to another health care provider for a second opinion when the request is reasonable; and

d. After the referral has been sent and before the patient has been seen, inform the consultant about clinically relevant changes in the patient`s condition or treatment.

3. Consulting physicians must:

a. Ensure they have an objective and consistent system to triage patients according to the urgency of the patient's condition and the availability of the physician;

b. Accept all referrals regardless of the referral source, unless:

i. the consulting physician cannot see the patient in a reasonable time frame based on the patient's described condition;

ii. the patient's described condition falls outside the consulting physician's scope of practice;

iii. the consulting physician has identified a conflict of interest; or

iv. the referral itself is insufficient for triage or fails to identify a concern warranting the consultant's involvement;

c. When refusing to accept a referral, the consulting physician must advise the referring physician immediately of the refusal, the reasons for the refusal, and, if the referral identifies a concern within the discipline of the consultant, refer the patient directly to an alternate consultant;

d. Upon accepting a consultation request, the consulting physician must:

i. provide a response to the referring physician or nurse practitioner within 14-21 days, acknowledging the referral and providing either the anticipated wait time or the appointment date. When a firm appointment date cannot be provided, this acknowledgment must still be supplied to the referring physician, along with an estimated appointment date;

ii. schedule the appointment directly with the patient. It is not the responsibility of the referring physician to notify the patient of the scheduled appointment. These requirements also apply in situations where the patient's appointment is rescheduled;

It is not uncommon for consultants to request additional information in advance of seeing the patient, perhaps by way of surveys, questionnaires or specific forms. Such requirements should not delay the triage and scheduling of patient appointments.

iii. arrange future care and follow-up appointments as required for the same issue with the patient and notify the patient;

iv. advise the patient of what the patient needs to do prior to the appointment and what they need to bring to the appointment;

v. advise the patient about any anticipated tests or procedures that may take place during the consultation. The effects of any tests or procedures should also be explained in advance, such that the patient can arrange for transportation or support as needed; and

vi. communicate expectations about any specific office procedures or policies relevant to the patient. These may include such things as mandatory masking, vaccination history or cancellation policies;

e. After seeing the patient, the consultant must:

i. review the results of all investigations they have ordered;

ii. act upon the results of all investigations they have ordered that fall within their scope of practice;

iii. if investigations identify significant findings outside their scope of practice (incidental findings), exercise professional judgment in response by either:

(i) consulting another physician, and informing the patient and the referring physician, or

(ii) advising the referring physician where the findings do not require an immediate or urgent response;

iv. provide the referring physician, family physician or nurse practitioner (or other primary care provider if applicable) with a timely written report that includes, but is not limited to:

(i) relevant history and findings of examinations,

(ii) conclusions regarding diagnosis (definitive/provisional, differential diagnosis where appropriate),

(iii) diagnostic and therapeutic interventions that were implemented and/or recommended,

(iv) outline all plans for consultant follow-up with the patient,

(v) where the patient's condition has stabilized or where the consultant is of the opinion that they can no longer provide value to the patient's condition, clearly communicate that the consultation is complete and all care is returned to the referring physician, and

(vi) provide the referring physician an interim report after subsequent visits, when in the opinion of the consulting physician, there has been a change in the patient's condition or management;

v. in the event the consulting physician is unable to generate a written report within 14-21 days of the patient encounter, the consulting physician must contact the referring physician, family physician or nurse practitioner directly to advise of the outcomes of the patient encounter; and

vi. After reviewing the referral, consulting physicians may decide they do not need to see the patient, as some referrals can be addressed by alternative means rather than an in-person visit. The consulting physician must provide a timely written response summarizing the rationale for not requiring a face- to -face assessment and the physician's recommendations for the patient's care.

Questions and answers to assist in application of the standard

1. **I have little or no managerial influence over my office staff because they are employees of the institution in which I work. How can I comply with this standard given that the roles and activities of my office staff are so critical to the referral process?**

   Referring physicians are often concerned when they cannot obtain the care, they deem necessary for their patients in a timely fashion. System issues do not mitigate your responsibility to the patient. When confronted by such issues, physicians are encouraged to contact each other directly. The goal is to provide reasonable care, not perfect care. To help demonstrate the reasonableness of your care, be sure to document any administrative or systemic issues that may impact the timeliness of a referral and consultation.

2. **My referral depends on the availability of diagnostic imaging, pathology services, or other third-party services over which I have no control. How can I comply with this standard given that so much of the process is out of my hands?**

   Limits on diagnostic resources are an unfortunate reality of today's medical environment. Despite these limitations, patients are entitled to know the approximate date of services ordered on their behalf.

3. **As a specialist, I often see consultation requests containing little or no information. An example is "Chest pain – please assess". What can I do about inadequate requests like this?**

   Referrals of this nature clearly fail to meet the provisions of this standard.

   Referring physicians are expected to provide complete, clear referral information. In the example provided, the consulting physician could not possibly triage the request appropriately. In the interest of both your patients and your peers, you may wish to raise your concerns in a collegial manner with the referring physician.

4. **I am a family physician. I recently referred a patient to a local specialist. The consultation letter I received from the specialist recommended that the patient be started on a particular medication. When I later saw the patient, I discovered that she had been taking the medication since seeing the specialist. How can such miscommunication be prevented?**

   Notes sent from consultants should always distinguish between interventions that were initiated by the consultant and interventions that the consultant advised the referring physician to initiate.

5. **I am a urologist who recently saw a patient on referral from their family practitioner. The patient has been treated successfully for a kidney stone. The patient should have an intravenous pyelogram in one year. Who is responsible for booking the test and notifying the patient?**

   As the IVP is a follow up exam related to the same urological issue, the consultant is responsible for booking the IVP and notifying the patient.

Resources

College of Physicians and Surgeons of Nova Scotia

- Professional Standards Regarding Transfer of Care

Canadian Medical Protective Association (CMPA)

- Wait times when resources are limited: Good Practice Guide - Referral-consultation process
- Accepting new patients: Guidance for specialists

Document History

First approved by the Council of the College of Physicians and Surgeons of Nova Scotia as *Guidelines for Physicians Regarding Referral and Consultation* on **March 26, 2010**. Re-approved on **December 13, 2013**.

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