

Referring safely

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ONE ISSUE that crops up regularly in cases dealt with by the AOP's legal department is that of referrals and events leading up to referrals. It seems very simple and it is easy to believe that you make a referral and that's the end of it. Very often that is true, but the process can also be fraught with dangers. Is the referral appropriate? Is it going to the right place? If referral is uncertain and repeat measures are required, do they take place?

It is important that referrals are made with the correct degree of urgency and to the appropriate place. It used to be said that the NHS recognised three levels of urgency – 'immediate, soon and routine'. Many will have discovered from experience that there may only be two levels in practice – urgent referrals (within 24 hours), and routine. You will know the situation in your area, but a referral you think is rated 'soon', say within a week, might be best referred as urgent if you feel 'soon' might end up becoming 'routine'. It is also important to remember that these days a referral to a GP has no guarantee of being dealt with urgently even if you have written that on the referral letter. Referring a retinal tear or a case of wet AMD via the GP is likely to be considered an inadequate referral. As a professional you know that this may well introduce delay, so such cases should be referred direct to an eye clinic or, failing that, to A&E with a suitable explanatory letter indicating the likely problem and the urgency. The patient's solicitors will have no hesitation in making accusations of inappropriate referral if an avoidable delay is introduced by the optometrist.

Repeat measures is another area of danger, particularly for locums

What should you do if a patient refuses to be referred? You should write to the patient and explain what you have found together with your advice, and you should enclose a referral letter for them to take to their GP (or to A&E if urgent). Send the letter "signed for" so that you have evidence of posting



and receipt, and you should retain copies of the letters with the patient's record.

Repeat measures is another area of danger, particularly so for locums who may not always be present to repeat their own procedures. Cases have arisen where tests have not been repeated because patients did not attend and were not followed up, where they were repeated by assistants but no-one then looked at the results, or where the action taken may not be the same as the locum would have taken. Regular locums should maintain a log of cases such as this and should check at future visits that the tests have been performed and suitable actions taken. Locums providing one-off cover are in a more difficult position. The ideal would be to ensure repeat tests are performed on the day where possible. Another option is to maintain a log and to follow up by phone to ensure the patient episode has been completed. This may seem onerous so another option is to leave written instructions for the contractor as to what should happen for that patient. Keep a copy of those instructions. Finally, if the locum is unsure that the patient will be followed up to their satisfaction they may be better to refer on the basis of the findings on the day.

Finally, it is a requirement to inform the patient in writing of the reason for their referral. This can be accomplished by writing a very short explanation on their prescription, but it is good practice to send the patient a copy of the full referral letter. This has the advantage of guarding against letters to the GP going astray, since the patient will have a copy. You may not always advise the patient to visit their GP to discuss the referral, but it is wise to ask the patient to telephone the surgery after a week or so to check that they have the referral and are acting upon it.

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