SOP: Patient Follow-up and Referral Management

This SOP details the procedure for **patient follow-up and referral management**, encompassing patient appointment scheduling, tracking patient progress, coordinating referrals to specialists, ensuring seamless communication between healthcare providers, documenting patient interactions, monitoring treatment outcomes, and maintaining comprehensive records. The goal is to provide continuous, coordinated care that improves patient outcomes and enhances the efficiency of healthcare services.

1. Scope

This SOP applies to all healthcare staff involved in patient management, including receptionists, nurses, physicians, and administrative personnel responsible for patient records and communication.

2. Responsibilities

Role	Responsibility
Reception Staff	Schedule and confirm appointments, manage referral documentation.
Nurses/Medical Assistants	Monitor patient progress, assist with communication and follow-up reminders.
Physicians	Evaluate patient progress, initiate referrals, review outcomes.
Administrative Staff	Maintain records, ensure secure data handling, coordinate correspondence.

3. Procedure

1. **Appointment Scheduling**
    - Receive follow-up or referral request from physician or patient.
    - Schedule appointment promptly in the electronic health record (EHR) system.
    - Confirm appointment with patient via preferred communication method (phone, SMS, email).

2. **Tracking Patient Progress**
    - Document each patient visit, interaction, or communication in the EHR.
    - Set reminders for follow-up as indicated by the treatment plan.

3. **Referral Coordination**
    - Identify need for specialist referral during assessment.
    - Prepare referral documentation including patient history, investigation results, and reason for referral.
    - Transmit referral documents securely to the receiving provider (electronically or by fax if required).
    - Inform patient of referral details including specialist contact information, location, and appointment date.

4. **Communication Between Providers**
    - Facilitate two-way communication between referring and receiving providers regarding patient status.
    - Follow up on specialist feedback and integrate recommendations into patient care plan.

5. **Documentation**
    - Record all patient interactions, appointments, referrals, and communications in the EHR promptly and accurately.

6. **Monitor Treatment Outcomes**
    - Evaluate patient progress at each follow-up.
    - Document any changes to the care plan, medications, or further referral needs.

7. **Record Maintenance**
    - Ensure all records are up to date, accurate, and compliant with confidentiality regulations.
    - Maintain backup copies and restrict access according to privacy policy.

4. Quality Assurance

- Conduct periodic audits of follow-up and referral records.
- Address gaps or bottlenecks in communication and documentation processes.
- Provide ongoing training for staff on updated procedures and technologies.

5. References

- Institutional Patient Care and Confidentiality Policies
- Local/National Health Information Privacy Legislation
- EHR User Manuals and Best Practices