MINISTRY OF HEALTH AND SOCIAL SERVICES

GUIDELINES FOR IMPLEMENTATING NATIONAL REFERRAL POLICY

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MINISTRY OF HEALTH AND SOCIAL SERVICES

GUIDELINES FOR THE IMPLEMENTATION OF THE NATIONAL REFERRAL POLICY

Directorate: TERTIARY HEALTH CARE AND CLINICAL SUPPORT SERVICES

PRIVATE BAG 13198
WINDHOEK
REPUBLIC OF NAMIBIA

TELEPHONE: +264 61 2032300
FAX: +264 61 234462
EMAIL: doccentre@mhss.gov.na

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Preface

The Ministry of Health and Social Services has put mechanisms in place to ensure functioning referral system in the public health sector. However the referral services are faced with problems such as inconsistent feedback amongst health care providers at all levels of health care services delivery, inadequate transport and shortage of human resources in general. Moreover, linkages between public health care facilities, Private Sectors and Community and Home based Care (CHBC) providers are not clearly defined. The abovementioned is a clear indication of poor linkages and retention to care, which in return hinder continuum of care for our patients.

To address the identified gaps, a National Referral Policy was recently developed which was followed by these guidelines for its implementation. These guidelines will facilitate timely referral of patients from one level of health care to another. The production of these referral guidelines were developed following extensive consultation within the MoHSS . Individual inputs were also sought among many stakeholders
The success of the implementation of referral system will depend on effective open communication, within/between referring and receiving organizations/facilities. Therefore, I trust that these guidelines will be used by all those involved in the referral of patients at all levels, for the benefits (just benefit) of our patients/clients.

I wish to acknowledge all those who participated in the development of these guidelines, in particular the contributions made by the Regional Health and Social Welfare Services Department, Directorate of Special Programmes and Quality Assurance Division. Special appreciation goes to our development partner IntraHealth International which is funded through the United States Agency for International Development (USAID).

I urge all public and private clinical teams and community and home based health care providers to familiarize themselves with these guidelines in order to strengthen linkages and retention to care and most importantly to ensure continuum of care for our people.

MR ANDREW N. NDISHISHI
PERMANENT SECRETARY

Abbreviations

AIDS – Acquired Immunodeficiency Syndrome
ANC- Ante- Natal Clinics
ALT – Alanine Amino Transferase
AST – Aspartate Amino Transferase
BPH- Benign Prostatic hypertrophy
CA - Carcinoma
CCF- Congestive Cardiac failure
CCU- Cardiac Care Unit
CBHC - Community Based Health Care Provider
COAD – Chronic Obstructive Airway Disease
CD4 – Cluster of differential 4
C/s Caesarean section
CT- Computerised tomography
CVA- Cerebro-vascular Accident
CXR- Chest X Rays
D&C Dilation and Curettage
DVT- Deep Venous Thrombosis
ENT – Ear, Nose, and Throat
ESR – Erythrocyte Sedimentation Rate
FB – Foreign Body
FBC- Full Blood Count
GE- Gastro Enteritis
HCW- Health Care worker
HIV – Human Immunodeficiency Virus
ICU – Intensive Care Unit
LFTs – Liver Function Tests
LP – Lumbar Puncture
MDR – Multi-Drug Resistance
MoHSS - Ministry of Health and Social Services
NSAIDS- Non- Steroidal Anti Inflammatory Drugs
NVD – Normal Vertex Delivery
Obs & gynae – Obstetrics and Gynaecology
ORIF – Open Reduction and Internal Fixation
ORS- Oral Rehydration Solution
PID – Pelvic Inflammatory Diseases
PTB – Pulmonary Tuberculosis
SLE - Systemic Lupus Erythematosus
STIs – Sexual Transmission Infections
SVC- Superior Venae Cava
U&E – Urea and Electrolytes
WCH -Windhoek Central Hospital

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1. INTRODUCTION

Referral systems exist between and within the three main levels of health care service delivery namely: Primary, Secondary and Tertiary levels. Referral forms and health passports are official referral tools that are being used between and within the 3 levels.

Although the referral system exists, the system lacks consistent feedback and tracking system to ensure that clients/patients had reached their destination and benefited from the appropriate services (Palliative Care Situational Analysis, 2009).The same study revealed that there are no standard referral procedures between public health care facilities and private sector, moreover, linkages between health facilities and Community and Home-Based Care (CHBC) Organizations), remain suboptimal despite the availability of the standardized referral forms provided in the National Community Home-Based Care Standards 2010.

Management Sciences for Health (2010) also reported that there are no clear linkages between services (facilities) and patients are lost from one point of care to another.

In response to the abovementioned gaps, the Ministry of Health and Social Services (MoHSS) developed a National Referral Policy 2013 on which these guidelines are based. The National guidelines describe the referral criteria and communication between the 3 levels of public health facilities. In addition, these Guidelines aim to standardize and strengthen the existing informal referral system between public health care facilities, private sectors and CHBC Organizations.

The need to extend the referral beyond the public health care facilities has become essential due to the complexity of the HIV Care and TB services. It is almost impossible for a single institution to provide holistic care to People living with HIV (PLHIV). HIV/AIDS and TB management goes along with broader needs that require additional services—delivered by both health facility and community. For this reason functioning bi-directional referral network amongst health providers at all levels of health care service delivery is crucial to ensure linkages and retention to care.

These Guidelines outline roles, functions and referral criteria to be used at Community level, Private Sector, Clinics and health Centres; District, Intermediate and National referral Hospitals. It also presents the communication and administrative procedures on referral services at these levels of health care.

1.2 Definition, goal and objectives of the Referral System

Definition

Referral can be defined as a process in which a health care worker/provider at one level of health care service delivery, having inadequate resources (medicine, equipment or technical skills) to manage a clinical condition, seeks the assistance from a different resourced facility at the same or higher level to manage the client's condition. Equally important health care facilities can also refer patients/clients back to CHBC for home based palliative care or support services available in the community. Referrals can be done from:

- CBHC Organizations to the nearest clinic for medical care
- Primary health care clinic to the district hospital for clinical diagnose and treatment
- District hospital to Intermediate Hospitals for specialist attention and management
- Intermediate hospital to the National Referral hospital for highly specialist service
- Public/Private health care facility, back to the community for home based palliative care and other supportive services
- Private sectors to public sectors on patient request or depletion of Medical Aid
- Public health care facilities to private sectors on patient request or for specialized services not available in public sectors

Goal of the Referral System

The goal is to ensure timely access to comprehensive health care services and continuum of care.

Objectives of the Referral system

- To standardize the current referral system and improve the patient care and safety.
- To strengthen the link between referring and receiving facilities/Organizations.
- To improve the consistence of consultation, transfer and transport process.
- To build/give confidence to patients, families, community and the HCWs.
- To enable Monitoring and Evaluation of the referral system.

These guidelines are produced as a tool for the implementation of the National Policy on the Referrals for Namibia. They were developed with the aim of explaining in detail, the referral criteria and procedures to be used at the different levels of health care service delivery.

2: Referral Processes

The primary health care providers discuss with the patient/client that a consultation may be warranted with another health care provider (eg, clinician, physiotherapist, social worker, lactation consultant, smoking cessation services, drug and alcohol services, mental health services etc) as the illness/disease would be better managed by, or in conjunction with, another health care provider.

Where a referral occurs, the decision regarding ongoing clinical roles and responsibilities must involve three-way conversation between the referring health care provider, the patient and the receiving health care provider. This should include discussion of any ongoing management of the condition by the referring and receiving health care provider. Clinical responsibility for the patients care remains with the referring health care provider until the patient is handed over to the next level.

Referral Process in the context of HIV entails that every patient/client who receives a positive HIV test result, whether from HCT, ANC and any other designated testing site will be referred to ART clinic in order to assess the need to begin ART. All HIV clients/patients referred to ART clinic will be enrolled into HIV care as per National ART Guidelines.

The patients/clients in need of support services whether on ART or not will be referred to the appropriate services (nutritional, spiritual, home based care etc…). In addition males testing HIV negative will be linked to Voluntary Medical Male Circumcision (VMMC) as part of HIV prevention strategy. They will be then offered with subsequent testing by the health care providers based on identified risk factors as stipulated in the HCT national Guidelines. .

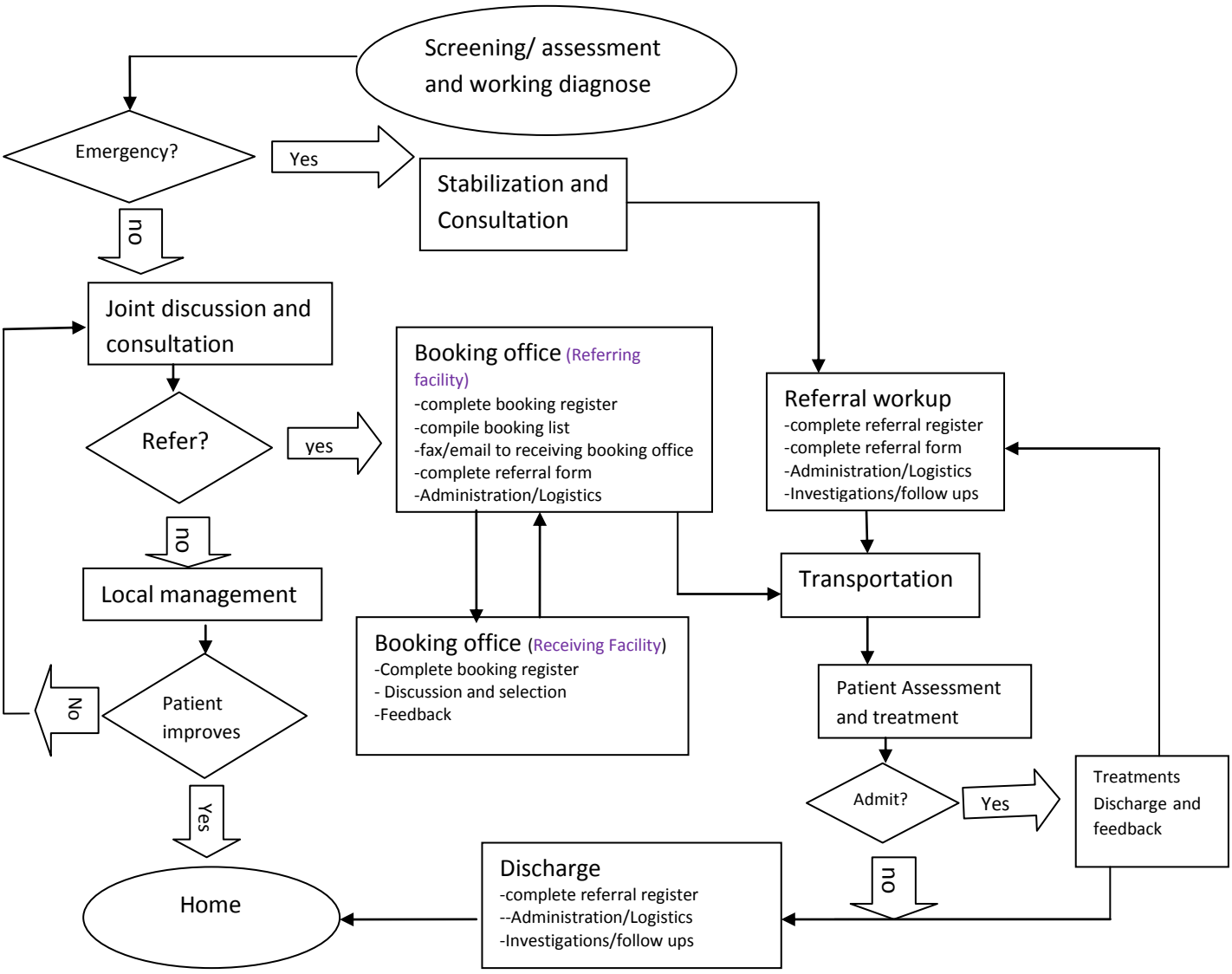
A feedback from the referred facility to the referring facility is required in order to ensure that patients/clients referred reached their destination. A follow-up by the referring facility will be conducted should the feedback not be received within expected period (Not exceeding 4 weeks).

2.1. Guiding principles

- The patient/clients and family are at the centre of all processes and discussions.
- Patients/clients should have continuity of care through a single point of contact for any services required.
- The patient has the right to receive accurate and unbiased information about treatment options and the likely outcomes.
- The patient has a right to make informed decisions on all aspects of her/his care, including the right to decline care, and to decline referral for specialist consultation or transfer of clinical responsibility.

- Practitioners are responsible for their clinical decisions and actions, and for acting within their competency and scope of practice.
- The approach to referral for consultation, transfer of clinical responsibility and emergency transport will be nationally consistent, with some flexibility for local needs and conditions.
- Communication between all practitioners managing the patient will involve the patient, and will be open, clear, timely and appropriately documented.
- Transfer of clinical responsibility is a negotiated three-way process involving the patient, the clinician and the practitioner to whom clinical responsibility is to be transferred.
- Practitioners are responsible for appropriately documenting their decisions, including any variation from the Referral Guidelines or other guidelines, and the circumstances of any such variation.

Figure 1: Referral Process



2.2 Categories of referral

There are two categories of referrals: elective and emergency referrals

Elective referrals: this refers to an elective consultation sought with the specialist for cold cases that do not need emergency treatment. The booking officer will in this case enter the patient details in the referral register after a referral letter is issued by the referring clinician and fax or email the booking list to the booking officer at the receiving facility.

The first contact of the patient (clinic, health centre, district hospital) is very important for the quality of care. It is expected that each level be able to manage the prescribed conditions/cases for that level. Beyond, these conditions and in case of limited capacity and equipment, the clinician will consult with the next level of care for accurate treatment.

At the clinics and health centre levels, patients will be referred to the district hospital, therefore, a referral form/health passport will be completed and the patient entered into the referral register.

At the district hospital, a clinician who identified the need for referral will consult with colleagues; once the team decides to refer the patient/client, the booking office will complete the booking register, compile the booking list and fax/e-mail to the receiving booking office. The booking office of the receiving facility will complete the booking register and feedback the referring facility after discussion and selection of accepted patients.

All accepted patients will be entered into the referral register, the referral forms will be completed, and issues related to administration and logistics arranged. The clinician will ensure that all pre-referral investigations are done timely. The patient will be transported to the next destination, where he/she will be admitted, treated and discharged with a feedback.

The referred patient/client is expected to reach the next destination within defined period depending on the condition, after this period lapses, the referring facility will do the follow-up with the receiving facility. In case the receiving facility did not yet receive the patient, he/she will be followed up using personal details.

Emergency referrals: this refers to a condition that requires immediate transfer of clinical responsibility for care from the referring doctor/nurse to the most appropriate available facility/practitioner (where possible).

Once a clinician identified the need for emergency referral, he/she should stabilize the patient discuss with colleagues (where applicable). Should the referral be agreed upon after consultation, a referral workup is paramount, including entering the client into the register, complete the referral form, handle all administrative/logistics, and ensure that all necessary

investigations are done. The referring facility has the responsibility to conduct a follow-up if feedback on the refereed patient was not received within a defined period.

At the receiving facility, the patient will be admitted, treated accordingly and discharged with a feedback to the referring facility. In addition, he/she should be entered into the referral register.

In addition to this, patients who present themselves at inappropriate level with conditions manageable at lower levels will be counselled and referred back with a note to that appropriate level.

3: Requirements/resources for the Referral System

In order to maintain the link and effectiveness of the referral system, certain requirements must be met including tools and infrastructure (committee and focal persons)

3.1. Directory of services

A directory of services provides an inventory of all registered CHBC organizations providing care and support services within a catchment area. The directory allows easy identification of services and organizations and facilitates the search for the most appropriate organization for referral and contact details. It is very important to update this directory quarterly as organizations initiate, expand or reduce services, and as focal or contact person change. The District Coordinating Committee in collaboration with Community and Home Based Care Organizations will be responsible for updating, maintaining and dissemination of the directory of services as changes occur.

3.2. Referral Form Book

The referral form book will consist of duplicated forms for smooth communication within and between facilities/organizations. The receiving care provider will temporarily keep referral feedback slips for all the clients they have seen/received and finally will be channeled to the facility's main referral file for monthly data compilation.

Handling of the feedback receipt

- In the event where the patient will return back to the referring organization, the feedback receipt will be handed over to the patient/client to submit it to the referring care providers whenever she go back for follow up. But this should not exceed 4 weeks.
- In cases where the patient is not likely to go back to the referring organization (e.g transfer out), the referral focal person will file the receipt and fax or email them to the referring organizations or inform the referring organization via telephone. Feedback should be given within 4 weeks period.
- Receiving institutions may device mechanism as to how to give feedback to the referring institutions in the absence of fax machine, email and telephone.

- Feedback receipt may be discarded after entered into the referral register or it may be handled like other official documents encase it may be needed for verification purposes

3.3. Referral Register

Each health facility and community based organizations should have a referral register for keeping track of the status of clients/patients' referrals. The referral register will contain information from the referring and receiving facility/organizations.

The referral register shall be managed by the focal person. He/she will be responsible for ensuring that the registers is updated on a daily basis, and for the tracking of clients/patients four weeks after the date of referral to verify whether they have reached their referral points and the required services was provided.

Information from the referral registers will be used to compile the monthly summary report form.

3.4. Referral focal person

All Health facility and Community Home Based Health Care Providers should identify an official who will have the responsibility to verify that the clients/patients reached their referral points and their needs were met, or if not, the reason and next steps.

Role of the focal person/booking office is to:

- Verify whether all referral cases where recorded into the referral register
- Collect all feedback receipt and complete the outcome column in the referral register
- Ensure that referring organization has receive the feedback at the appropriate time
- Track patients incase feedback was not received after 4 week period, this can be done through phone calls or emails and again record the findings in the referral register
- Compilation of the monthly summary report and present to the committee that deals with referrals.

3.5. Referral committee

Each public health facility should identify a suitable existing committee that will address referral cases. The ideal committee should be a multidisciplinary committee with representatives from the Regional Management Team members, District Coordinating committee members and representative from the Community Based Health Care Providers.

The committee will have the responsibility to monitor and evaluate the referral system and address challenges faced within the system. The referral committee should meet on monthly basis.

3.6. Referral reports

The referral summary report should be compiled from the referral register, on a monthly basis.
The committee will scrutinize the referral report that will be presented to the committee members by the referral focal person on a monthly basis. Identified gaps will be discussed and addressed during the meeting.
The following information will be collected on a monthly basis:

- Total referrals made by the facilities.
- Total referrals received from other organizations/health care facilities
- Number of patient/client reach destinations and benefited from the required services
- Number of patient/client lost to followed-up and not traced
- Number of patient/client traced

4: Roles and responsibilities

In order to implement the referral system successfully, an integrated approach from the national, regional, district facilities and community levels need to be adopted. This includes well defined roles and responsibilities for all these levels, ensuring active involvement of all stakeholders and availability of relevant recourses as stipulated in The National Referral Policy 2013.

4.1. National level (Directorate Tertiary Health Care and Clinical Support Services)

- Provide policy guidance and leadership to all regional health directorates and other stakeholders
- Review the National Referral Policy and Guidelines in collaboration with regional health directorates to ensure that referral guiding documents are in line with new developments
- Disseminate reviewed documents to regional health directorates, private sector and CHBC organizations

4.2. Regional Management Team and District Coordinating Committee

- Disseminate referral Policy and Guidelines to all health facilities
- Ensure consistent supply of Referral Tools
- Create a platform to discuss referrals with relevant stakeholders
- Monitor and evaluate the implementation of the referral system

4.3. Community and Home Based Care (CHBC) Organizations

Referrals are a crucial component of CBHC services. CHBC Organizations should establish linkages with health facilities and other organizations providing health care services, within their catchment area. Referral and networking are essential to ensure continuity of quality

care for the client at all times. The MoHSS will ensure that up to date referral tools are available to all registered CHBC providers.

Referring a client will be deemed necessary:

- For continuity of care from the health facility to other caring services/organizations within the community
- From family level back to the health facility
- To access Government services when a client/or family members meet criteria e.g. OVC grants
- For specialized care, treatment or support;
- When the CHBC provider has limitations in meeting certain needs of the client or is experiencing burn out and need to suspend care for a while

CHBC Organizational managers should ensure that their health care providers are empowered to be able to:

- recognize the need for referrals
- know when a referral is required
- consult as needed to determine the source of required services and
- assist the clients and their families to make informed decisions.

CBHC Provider should strengthen the collaboration amongst other organizations in general and public health care facilities in particular to ensure that referrals are done promptly and appropriately. The link will certainly be strengthened once CHBC providers are represented at relevant health care facility committee and participate in regional Home Based Care forums.

4.4. Private Sector

Private patients need to benefit from comprehensive treatment, care and support services. Hence, all chronically ill private patients need to be referred for care and support services if they wish so. Patients who can no longer afford the cost for private sector must be officially referred to the public sector for continuum of care.

- Private practitioners must acquaint themselves with the MoHSS National Referral Policy and Guidelines.
- Private practitioners should collect standardised referral tools from the Directorate: Tertiary Health Care and Clinical Support Services, Ministry of Health Head Office, to maintain uniformity.
- Ensure that all patients referred to the public health facility reach their destination.

- Private practitioners should also strengthen the collaboration between the public health facilities in their catchment areas

5: Referral Criteria in a Public Health Facility

5.1 Clinics

Clinics (and health centres) are the first line health institutions providing preventative, promotive, rehabilitative and basic curative care.

Functions of clinics

The following functions are carried out at clinics:

a) Preventative services
b) Health promotion service
c) Supervisory services to community based health care activities
d) Basic curative services

Conditions that can be managed at the clinics

a) Uncomplicated pneumonia
b) Uncomplicated malaria
c) Diarrhoea
d) Mild soft tissue injuries
e) Burns of first degree and low percentage less than 20%.
f) Ante-natal visits ANC
g) Infections
h) Normal Vertex Delivery (NVD) in case of emergency and uncomplicated delivery for remote clinics
i) STIs

5.2 Health centres

Like clinics, health centres are the first line health institutions providing preventative, promotive, rehabilitative and basic curative care.

Functions of Health centres

The following functions are carried out at clinics and health centres:

e) Preventative services
f) health promotion service
g) Supervisory services to community based health care activities.
h) basic curative services
i) basic Rehabilitative services to chronic ill patients

Conditions that can be managed at health centres

j) Uncomplicated pneumonia
k) Uncomplicated malaria
l) Diarrhoea
m)
n) Mild soft tissue injuries
o) Burns of first degree and low percentage less than 20%.
p) Ante-natal visits ANC
q) Uncomplicated deliveries and post natal care
r) Simple fracture of the limbs where medical officer is available.
s) Infections
t) Normal Vertex Delivery (NVD) in case of emergency and uncomplicated delivery for remote Health centres
u) STIs

The patients treated at a health centre should be given appointment to come back after 72 hours and must be referred to a district hospital if no improvement is observed. A patient should not be admitted at the health centre for more than 72 hours. After 72 hours the patient should either be discharged or referred to the next level of care if there is no improvement.

Conditions that should be referred to district hospitals

Patients from clinics and health centres with complicated or difficult conditions that cannot be handled by the health care workers at clinics and health centre level must be referred to the district hospital. These are:

Specific conditions

a) Follow-up patients with hypertension, epilepsy, psychosis, diabetes, HIV/AIDS, leprosy
b) Congestive cardiac failure (CCF)
c) Patients requiring admission
d) Patients who require special investigation after consultation with clinician at the next level of care
e) Newborns with any abnormalities
f) Children with failure to gain weight and growth
g) Any severe skin rash needing hospitalisation
h) Any case of gastro enteritis GE that is not responding to first line treatment and Oral Rehydration Solution (ORS) within 48hrs.
i) Complicated malaria
j) Any patient with severe anaemia
k) Any patient suspected with pulmonary tuberculosis (PTB)
l) Multiple pregnancy
m) Primigraviders,
n) Anaemia in pregnancy
o) Abortions

p) Mal presentation
q) All high risk pregnancies e.g pre-eclampsia & Eclampsia because of lack of medication, Pre-term delivery < 34 weeks

5.3 District Hospitals

District hospitals are the second line health care institutions. They are staffed by medical officers, nurses and paramedics and are providing secondary and primary health care services.

Functions of a district hospital

a) Clinical diagnosis and treatment
b) Human resources development in the form of on job training.
c) Supervision of clinics and health centres including medical officers outreach services to these facilities.
d) Serves as a referral centre for clinics and health centres
e) Renders preventative, promotive, rehabilitative and curative services.

Conditions that can be managed at a district hospital

General surgical procedures

a) Hernia repair (uncomplicated)
b) Hydrocelectomy
c) Circumcisions
d) Treatment of phymosis
e) Appendecectomy
f) Incision and drainages
g) Pneumothorax/ haemothorax management/ under water seal drainage
h) Pleural effusions
i) Urinary retention
j) Simple fractures
k) Dislocations
l) Foreign body removal from eye, ear, nose
m) Epistaxis control
n) Excision of most lumps- lymphomas, fibro adenoma etc
o) Caesarean section
p) Dilation and curettage (D&C), evacuations
q) Ectopic pregnancy
r) Poisoning
s) Pelvic Inflammatory Diseases (PID)

t) Burns
u) Biopsy of breast lumps.
v) Excision and biopsy of any suspicious skin lesions
w) Stabilization of patients with emergency conditions before referral
x) Follow up of post-operative patients from intermediate hospitals.
y) Dental Services
z) Ophthalmic Services

General medical conditions

a) Infections
b) Poisoning
c) Inflammatory processes
d) Diabetes
e) Thyroid diseases
f) Asthma
g) Hypertension
h) HIV/AIDS
i) Leprosy
j) TB
k) Cancer
l) Deep vein thrombosis (DVT)
m) Varicose veins
n) Cerebrovascular accident (CVA) strokes
o) Headaches
p) Anaemia
q) Thrombocytopenia
r) Coagulation disease
s) All general medical conditions at terminal stages requiring only supportive and palliative treatment
t) Diarrhoea

Conditions to be referred to an Intermediate Hospital

Cases treated at district hospitals without improvement should be referred to the intermediate hospitals should there not be any alternative treatment at that level. These include conditions requiring diagnostic investigation and management not available in the district hospital.

Patients with surgical emergencies who need to be referred to the next level of health care services must be referred within four (4) hours after stabilization. Within one hour of making a diagnosis of obstetric complication, patient in labour must be referred. Medical emergencies should be stabilised and referred within two (2) hours of arrival in the hospital.

Surgical and orthopaedic emergency

a) Extensive trauma
b) Spinal injuries
c) Head injury moderate and severe
d) Fractures requiring open reduction and internal fixation (ORIF)

e) Acute abdomen pain
f) Complicated hernias
g) Acute bowel obstruction
h) Peritonitis
i) Kidney problems
j) Complicated peptic ulcer
k) Acute cholecystitis
l) Foreign body (FB) of the oesophagus, eyes and airways
m) Complicated Appendicitis
n) Pelvic abscess
o) Severe burns

Obstetric and gynaecological emergency

a) Placenta prevea
b) Abnormal foetal presentations if External Cephalic Version might be considered.
c) Acute complications in pregnancy
d) Complicated post natal eclampsia
e) Patient with high risk of obstetric history at least at 38 weeks gestation

Medical and paediatrics emergency

a) Diabetic pre-coma and coma
b) Hypertension crisis not responding to common treatment
c) Acute cardiac and respiratory failure
d) Uncontrollable epileptic fits
e) Acute renal failure.

Surgical elective referrals

a) Incisional hernia, extensive abdominal and diaphragmatic hernias
b) Suspicious tumours
c) Chronic cholecystitis with or without obstructive jaundice.
d) Goitre
e) Elective surgery of stomach and duodenum
f) Patients require elective splenectomy
g) Varicose veins of lower limbs
h) Elective surgery of the lung
i) Congenital and post-traumatic malformations of the limbs
j) Conditions after Open Reduction and Internal Fixation (ORIF), removal of implants
k) Osteomylitis
l) Urological elective cases
m) ENT elective operations
n) All eye conditions not improving with conservative treatment
o) Congenital malformations
p) Ovarian cysts

Medical and paediatrics elective

a) Complicated uncontrolled endocrine disorders

b) Uncontrolled hypertension
c) Congestive Cardiac failure (CCF) and rheumatic heart diseases
d) Uncontrolled renal disorders
e) Complicated infections not responding to treatment
f) Complicated TB MDR (consult)

Obstetrics and gynaecology elective

a) Pelvic tumours
b) Complicated chronic PID
c) Infertility
d) Corrective and reconstructive surgery in gynaecology

Psychiatry or mental disorders elective

Cases treated at the district hospital without improvement should be referred after 72 hours to the intermediate referral hospital.

5.4 Intermediate hospital

Intermediate Referral hospitals are third line medical institutions where tertiary and secondary services are rendered.

Functions of intermediate hospitals

a) Provision of training (pre and in-service training)
b) Induction programme
c) Health education
d) Supportive, supervision and training to regions and districts
e) Implementation of quality assurance guidelines within regions
f) Operational research

Conditions that can be managed at intermediate hospitals

Gynaecology

a) Complicated amenorrhea
b) Infertility- investigate and treat
c) Complicated urinary incontinence of gynaecological origin
d) Complicated faecal incontinence of gynaecological origin
e) Complicated uterus-vaginal prolapse
f) Benign neoplasm of the genital tracts
g) Abnormal uterine bleedings
h) Uncomplicated endometrial carcinoma and sarcoma
i) Pre- referral work-up according to the guidelines

Obstetrics

a) Uncomplicated cardiac diseases grade I and II in pregnancy
b) All pregnant diabetic patients with complications Multiple pregnancies/mal presentation

c) Hypertension disorders in pregnancy
d) History of pre-term delivery <34/40 weeks or intra-uterine growth retardation.
e) Elective Caesarean section (c/s) – for 2 previous/ more
f) Placenta previa
g) Congenital abnormalities of genital tract
h) Past history of pregnancy related to bleeding likely to deteriorate with current pregnancy
i) Multiple pregnancies with complications
j) Polihydomnios
k) Grand multiparity
l) All pregnant women whose diagnoses are uncertain and beyond district medical officers capabilities
m) Pregnant women with conditions requiring advanced management not available in the district amongst others:.
    - Lung infections requiring interventions
    - Cardio- vascular diseases
    - Diseases requiring specialist drugs
    - Different types of congenital malformations
    - Haematological diseases
    - Uncontrolled psychiatric conditions for evaluation and diagnosis
    - Neurological conditions beyond district level
    - VIP strokes

Internal medicine and paediatrics

Cardiology

a) Congenital cardiac defects for intervention
b) Complicated rheumatic heart disease
c) Complicated arrhythmia
d) Unexplained heart failure

Neurology

a) Strokes in- patient more than 45 years with cardio vascular problems or other treatable condition.
b) Stroke of gradual onset
c) Convulsions without any obvious cause
d) Uncontrolled epilepsy
e) Epileptic work- up on convulsion without any other obvious causes and localizing neurological signs
f) Status epilepticus
g) Tetanus
h) Guillian Barre Syndrome
i) Acute paresis- no trauma involved
j) Patients with connective tissue diseases
k) Myopathies dermatomyositis etc.
l) Coma of unknown cause or exclusion of any other cause
m) Unexplained arthritis.

5 Respiratory problems

a) Complicated pneumonia
b) TB complications
c) Multi-drug resistance (MDR)
d) TB Drug induced hepatitis
e) Peripheral neuropathy
f) Croup- non resolving
g) Non-resolving asthma,
h) Chronic obstructive airway disease (COAD)
i) Superior Vena Cava (SVC) Syndrome to be referred to the radiation oncology department once discussed with radiation oncologist.

Haematology

a) Bleeding tendency without improvement within 2 weeks
b) Patients who need bone marrow aspiration

NB: Referrals of highly contagious conditions must be avoided.

Endocrinology

a) Thyroid problems not requiring any surgery
b) Complicated diabetes mellitus
c) Pituitary gland pathology
d) Gynaecomastea
e) Active hepatitis > 6/12 with AST, ALT elevation
f) Liver failure

Renal failure

a) Nephrotic syndrome

Patients diagnosed as end stage renal failure should be referred to the national hospital for transplant. While waiting for a transplant the cause of the renal failure needs to be treated e.g.

- Infections
- Hypertension
- Diabetes mellitus
- Fluid overload
- Electrolyte abnormalities
- poisoning

Hypertensive patients

a) Young patients (to rule out secondary causes)
b) Patients with complicated hypertension
c) Patients with uncontrolled hypertension which is not due to poor treatment compliance.

Mental health

Physical organic causes of the condition should be ruled out prior to referral. Patients have to be accompanied by somebody who can give collateral information. If not possible the referring person must supply the detailed history of the patient. If the patient has received medication the type, dosage, time of administration need to be indicated.

In case of emergency, the referring person should first discuss the case with the doctor on call at the mental health care centre. Cases which do not require emergency attention should be referred to internal medicine and not psychiatry.

Children with learning difficulties should be referred to education psychologists/school counsellors/clinical psychologist. Disability pension form has to be completed at the respective places of patients- health centres and hospitals.

Mental Health Referrals

a) Acute psychosis (unexplained symptoms) should be referred to internal medicine or paediatrics to rule out organic pathology.
b) Chronic cases as well as family history of psychosis should be referred to psychiatry
c) Epilepsy complicated by chronic behavioural disturbances
d) A highly suicidal patient in a physical stable condition
e) A patient with aggressive/ disrupted behaviour
f) Dementia patients
g) Acute schizophrenia
h) Acute confusion state
i) Severe depression
j) All children with psychiatric disorder

Oncology

All patients with early cancer must be referred as soon as possible preferably with histological confirmation. Patients with advance cancer should be referred only if in good general condition. Patients should be referred to the relevant departments in Windhoek. The relevant departments will refer the patients to medical, oncology or radiation oncology or further investigation.

All cancer patients should be referred with:

a) a referral letter with doctors' signature and written name and contact telephone number
b) Histology/ cytology reports; Radiology reports
c) all surgical details
d) any previous treatments
e) past medical history

Patient under18 years should be accompanied by a parent or guardian. All cancer patients requiring individual assessment and treatment should be referred. All proven paediatric cases of malignancy should be referred to the national referral hospital, and chronic known cases to oncology

The following cases can be discussed with the radiation oncologist before referral for radiation treatment

a) Spinal cord compression
b) Superior vene cava syndrome
c) Known brain metastasis which are causing convulsions, blindness and uncontrolled behaviour

Oncology Referrals:

a) Confirmed Kaposi Sarcoma
b) HIV- related Kaposi Sarcoma- and lymphoma patients may be referred if in good general condition and CD4 count if available above 50
c) Co-morbid medical conditions like tuberculosis, syphilis, pneumonia, skin sepsis all other infections, cardiac failure, renal failure e.tc should first be treated in the peripheral hospitals and patients referred if / when they recover,
d) Poor haematological indices should be corrected before referral for blood transfusion
e) Cancer patients with follow up dates who deteriorated unexpectedly should be discussed with medical oncology telephonically before referral.

Contraindications

a) Terminal patients- were life expectancy is less than few days- should NOT be referred, rather discuss treatment telephonically.
b) Patients with carcinoma of cervix with vesico-vaginal or recto-vaginal fistulae cannot receive radiotherapy and should receive palliative treatment at nearest hospital or clinic.

Surgery

a) Trauma/ emergency
b) Aggressive resuscitation
c) Initiate definitive care in life threatening chest injuries and abdominal juries
d) Head injuries
e) Burr holes, craniotomy for extra Dural haematomas
f) Spinal injuries
g) Splinting, prevent conversion of non-spinal injuries to spinal injuries
h) Penetrating trauma
i) Vascular/nerve/tendon repair
j) Elective non cancer surgery
k) Thyroid
l) Breast cancer
m) Salivary gland
n) Elective cancer surgery – to coordinate with the oncologist at the national hospital for plan on adjunctive therapy, for staging, for uniformity and treatment protocols.

Paediatrics surgery

a) All general paediatric problems e.g. bowel obstructions
b) Thyroglossal duct cyst-sinus
c) Paediatric scrotal emergences
d) Neonatal emergencies
e) Artesia

All primary work up should be done including primary surgery prior to referral to the paediatric surgical unit at the national hospital.

Orthopaedics

a) All limb fractures
b) Pelvic fractures

Burns

a) All burns including- inhalation burn injuries

Foreign bodies

a) Aero digestive tract

ENT

All cases outside the competence and available equipment at the intermediate referral hospitals should be referred to the national referral hospital. Referral should be done as soon as possible subject to the time required stabilising the patient for possible safe transportation.

5.5 National Referral Hospital

This is the apex referral centre of the country that has to handle all referral cases not manageable at the intermediate referral hospitals. The service is characterized by highly specialized staff: nurses, doctors and paramedics. The national hospital sets the gold standard in providing services and expertise to the nation. The diagnosis and therapeutic facilities are of highest medical level.

5.5.1. Functions of the national Referral hospital

A National Hospital provides all general services, such as:

a) Advanced training
b) Pre-service training
c) In-service training
d) Induction programmes
e) Supportive training
f) a centre for sub regional cooperation and sharing of expertise in the region in research
g) Quality assurance
h) sets standards for quality patient care

i) Conducts internal and external audit
j) Promote, provide, monitor academic research activities
k) Conducts supportive visits to the intermediate referral hospitals
l) Establishes and encourages the use of electronic communication systems
m) Serves as a role model for improved communication among the multi-disciplinary team members and regional referral centres.
n) Conducts annual review of the referral system and report to the relevant stake holders
o) Provides feedback to the referring institutions and patients/ clients
p) Visits the intermediate hospitals to share expertise

5.5.2. Specialised services provided at a National Referral Hospital:

a) Laminoflow
b) ENT reconstruction
c) Neurosurgery
d) Lung functioning
e) Nuclear medicine
f) Medical oncology
g) Radiation oncology
h) Specialized radiography examinations e.g. CT scan, Angiograms
i) Maxilla facial surgery
j) Dialysis
k) Neonatal intensive care
l) Paediatric specialist surgery
m) Cardiac services
n) Forensic psychiatry
o) Surgery (general and orthopaedics)
p) Internal Medicine
q) Obstetrics and gynaecology
r) Paediatric services
s) Ophthalmology, and
t) forensic pathology services

5.5.3. Specific specialised conditions

a) Breast reconstruction
b) Vascular surgery
c) Pancreatio- billiary tract diseases
d) Colo- rectal cancer
e) Oro- pharyngeal cancer
f) Plastic/ reconstructive surgery
g) Paediatric surgery unit
h) Cardiac- thoracic surgery unit
i) Neurosurgery
j) Surgical oncology
k) Any other specialised conditions

6: COMMUNICATION AT THE PUBLIC HEALTH FACILITIES

The success of the implementation of the referral policy and guidelines depends greatly on effective communication. Effective communication entails open communication within the referring health facility as well as within the receiving one and more so between the two. This communication will ensure that the relevant patients according to the set criteria are referred in time accompanied by all relevant information that is required by the receiving health facility.

6.1 At clinics and health centres

The referring clinician should communicate with the receiving district hospital through patient health passport. Prior to referral of patients to the district hospital, a comprehensive history of the patient should be obtained and documented in the patients' health passport/referral letter. All patients referred from the clinic and health centre should have a working diagnosis.

6.2 At District hospital

There will be designated booking offices at district, intermediate and National Referral hospitals. The booking offices are a vital link between the referring and receiving health facilities. They should be equipped with a telephone, independent fax line and internet connection in order to facilitate the carrying out of their pivotal role of coordinating the referrals. All cold cases should go through the booking offices. The referring clinician and receiving clinician should communicate about cold cases by means of available communication facilities.

All necessary investigations must be reflected in the patients' health passport and referral letter. Patient's referred to intermediate hospitals must be confirmed during grand rounds according to the referral criteria. The medical head of section should take responsibility of compiling the list of confirmed patients to be referred, and send it to their respective booking offices. The booking offices in turn compiles a booking list including patients from all sections/ subsections of that health facility and communicated this list to the booking office of the next level.

The referred patients shall be accompanied by a duly completed referral letter. Appropriate consent forms for operations in regard to minor patients and patients with mental disorders should be signed in accordance with the provision of the law.

In order to improve the communication between referral hospitals there is a need to have them electronically connected through internet. The district hospitals should communicate the feedback to the clinics and health centres through the patient health passport.

6.3 At Intermediate hospital

The booking office should be the centre of communication. All patients at intermediate level that need referral to the national level should be confirmed during grand rounds. Patients' pre-referral workup should be done and documented in the referral letter. A working diagnosis should be clearly recorded in the referral letter. The list of all confirmed patients should be drawn up by the medical head of section and communicated to the booking office which in turn communicated to the booking office at the national referral hospital. The booking office of the intermediate hospitals should give feedback to district hospitals.

Like in the case of a district hospital above, consent forms for operations in regard to minor patients and patients with mental disorders should be signed in accordance with the provision of the law.

All feedback from the intermediate hospitals should be through referral letter and patient health passport. All patients referred further to the national referral hospital should also be accompanied by a comprehensive referral letter.

6.4 At National referral hospital

The booking office at national level handles all cold cases referred from the intermediate hospitals. In case a patient is to be referred further, the booking office of the national referral hospital has the responsibility to inform the respective intermediate hospital about this.

All feedback from the national referral hospital should be through referral letter and patient health passport. All patients referred further from the national referral hospital should also be accompanied by a comprehensive referral letter.

6.4.1. Emergency referral

Telephonic communication between referring and receiving clinicians is mandatory. Emergency referral should be arranged by clinician to clinician therefore no booking should be arranged. However a comprehensive emergency referral letter should accompany the patient. In an emergency referral the clinician should indicated the most appropriate mode of transportation of the patient.

On discharge from the receiving health facility, a detailed clinical feedback should accompany each patient with the signature of the relevant medical officer.

6.4.2. Communication on transportation of bed ridden patients at different referral levels

It is the responsibility of the booking office of the discharging hospital to inform the receiving hospital about discharged bedridden patients. The booking office hands over the

responsibility to the nurse in charge of casualty during public holidays, Sundays and after hours. The ambulance drivers of different levels of hospitals should contact the booking office/nurse in charge of casualty about their discharged patients.

6.4.3. Information about death of referred patients

When a patient dies at the receiving hospital, the nurse in charge of the ward where the patient died communicates the information to the booking office of the hospital. The booking office in turn communicates the information in writing through fax or email to the referring hospital's booking office. The referring hospitals booking office takes the responsibility to inform the family. After hours, weekends and public holidays the sister in charge of the receiving hospital should phone the sister in charge at the referring hospital.

6.4.4. Progress reports of patients who were referred as emergency cases

The receiving hospital should inform the referring hospital about the condition of the referred patients through the booking offices. Summary of procedures or medication given and further plan should be furnished in a feedback paper/health passport.

6.4.5. Catering for patients discharged from hospitals

It is the responsibility of the Ministry of Health and Social Services to feed the referred patients until they are discharged. The discharging hospital should inform the receiving hospital about the number of discharges in order for those hospitals to prepare meal for patients on arrival.

7. ADMINISTARTIVE SUPPORT

The current referral system is functioning with a lot of constraints. In order to ensure a functional and effective referral system these administrative guidelines should be followed.

7.1. Transport

The ministry is responsible for transporting emergency referrals from clinics and health centres to district hospitals. The ministry shall not be responsible for transporting cold cases from clinics and health centres to district hospitals. Starting from the district hospitals through to national referral hospital the Ministry will transport cold and/or emergency cases from one level to another. Patients/clients who called from home should be also considered for transportation.

The patients' bus shall strictly transport referred patients only. A list of patients to be transported should be compiled and handed to the nurse accompanying the patients. There shall be a reliable transport fleet at all times as well as adequate funding for fleet maintenance at all levels. All ambulances and patient buses at all levels should be provided with communication facilities.

It is the responsibility of the referring hospital to transport back the corpses of the referred patients who die while in the care of the receiving hospital as soon as possible. Suitable vehicles must be acquired for this purpose.

7.2. User Fees

All patients referred from one level to the next level shall not be expected to pay admission fees at the receiving health facility provided that they paid at the referring facility.

7.3. Lodgers

Depending on the distances between the referring and receiving hospitals, provision should be made by the referring hospital for meals/ lunch packs for all referred patients and lodgers.

The receiving hospital must provide meals on arrival. The lodgers' policy must be strictly observed in all referral cases. Breast-feeding mothers and one parent/ guardian per minor younger than 8 years should be considered as lodgers. In the case of psychiatric patients being referred for the first time, a relative must accompany such patient and be regarded as a lodger. Follow up psychiatric patients need no relative/escort

7.4. Booking Register

Each section/ subsection must keep a booking register for all referred patients. This register must be completed by the registered nurse in consultation with the clinician. The intermediate hospitals should be provided with duty rosters and telephonic contact numbers of all consultants at the national level to facilitate telephonic consultations.

7.5. Staffing

All referral hospitals must be equipped according to their functions and level of health care and must be staffed according to their staff establishment. All staff at all levels should be appropriately trained. This will ensure a proper functioning of the referral system.

In addition, Medical superintendents should review the functioning of the referral system once a year and should present reports to the national management meeting.

Table 1: Workup of cancer patients before referral to oncology

TYPE OF CANCER	WORKUP TO BE DONE
Kaposi Sarcoma	Histology;HIV- status; CD4;CXR
Skin cancers/ melanoma	Histology; CXR (melanoma)
Brain tumours	SXR; CT or MRI scans; Histology if possible; CXR
Eye tumours	Histology; SXR, CXR and CT scans; ophthalmic exam
ENT and head and neck cancers	Endospcopic findings; Histology; SXR sinuses/ CXR and CT scans; MRI if possible; FBC
Lung cancers	CXR; CT scan thorax; Histology or sputium cytology; FBC; Lung function test
Oesophagus cancer	BA-swallow; Oesophagosocpy findings; Histology; CXR;
Gastric cancer	BA- meal; Gastroscopy; Histology; CXR,CT scan; Operative findings; Radio-opaque clips for radiotherapy; Ultrasound abdomen; FBC/ LFTS
Colorectal cancer	Histology; Double contrast BA- enema/ colonoscopy; CT scan; Operative findings/ radio-opaque clips for radiotherapy; CEA(tumormaker)
Cancer pancreas	FBC/LFT; Ultrasound/ CT scan; CA 19-9 (tumormaker); Histology if possible, FBC/LFT
Cancer anus	Histology; BA-enema; Sigmoidoscopy findings; FBC
Renal cancers	Histology; CT scan, CXR; Ultrasound; IVP Operative findings/ radio opaque clips for radiotherapy; FBC/ U&E
Cancer bladder	Histology; Cystoscopy findings/ operative; Bilharzia; FBC/U&E
Testicular cancers	Histology; CXR; CT scan; Ultrasound abdomen; A-fetoprot/ beta- HCG (tumour makers); FBC/U&E
Prostate cancer	Histology; Prostate sixe; PSA (tumormaker); XR/ bone scan; FBC/U&E
Cancer of penis	Histology; FBC; CXR; CT scan
Cancer vulva/vagina	Histology; Full gynae exam; FBC; CXR
Cancer of cervix	Histology; EUA and cystoscopy; IVP; Ultrasound abdomen; CXR; HIV/FBC/U&E
Endometrial cancers	Histology; Operative findings; Ultrasound; IVP; CXR; FBC/U&E
Ovarian cancers	Histology; Operative findings; Ultrasound abdomen/pelvis; CXR; CA 125 (EPITHELIAL

	CANCER TUMORMAKER) A-fetoprot/ b-HCG(germ cell tumormakers)
Gestational trophoblastic disease	Histology; b- HCG; CXR; FBC
Breast cancers	Histology; Operative findings; CXR; Ultrasound liver if indicated; CA 15-3 (tumormaker); Mammograms FNA; FBC/LFT
Thyroid cancers	Histology; Operative findings; T4 + TSH; CXR
Neuro-endocrine cancers	Histology; Operative findings/ radio-opaque clips for radiotherapy; Ultrasound/ CT scans; CXR; FBC/U&E/LFT/ amylase; VMA/5-HIAA if indicated
Sarcomas	Histology; Xr/CT scans; Operative findings/ radio-opaque clips; Bone scan; CXR; FBC/U&E/LFT
Lymphomas/ Hodgkin's disease	Histology; Operative findings; FBC/ESR/LFT+ LD; HIV+ CD4; CXR; Ultrasound abdomen or CT scan Bone marrow biopsy; Flowcytometry on bone marrow aspirate
Leukemias	FBC+ diff count + ESR; Bone marrow biopsy; Cytogenetics; Flowcytometry; HIV+ CD4; CXR LFT+ LD
Multiple myeloma	x-rays; histology if possible; bone marrow biopsy; FBC/ ESR/Protein- electrophoresis/ Bencejones prot./ immunoglobulins/ ca++ U&E
Metastatic cancer- unknown primary	Fine needle aspiration- cytology/histology; CXR; Ultrasound/ CT scans; Endoscopies; BA-studies; Mammogram; Tumour makers: CA125;CA15-3;CEA; CA19-9;PSA
Suspected neck bone metastases	FNAB of enlarged neck bone; ENT exam and pan endoscopy to search for primary cancer; If lymphoma is suspected on FNAB, dissect whole lymph nodes out for histology; If metastatic squamous CA –DONT do incision biopsy, continue to search for primary or refer to oncology; Bone marrow biopsy; CSF; CXR
Lymphomas	Histology; CXR; Ultrasound abdomen/ CT scan; CSF; FBC/U&E/LFT+LD; HIV+CD4

Annex A: General Referral Forms

REPUBLIC OF NAMIBIA

MINISTRY OF HEALTH AND SOCIAL SERVICES

HIV Treatment and Care Patient Transfer Form

Part A: To be completed by the referring care provider:

Health facility referred from: _____ District: _____ Region: _____

Tel. No: _____ Fax No: _____ E-mail: _____

Client/Patient Unique number : _____

Client/PT. Surname: _____ First Names: _____

Date of Birth: _____ Age: _____ Sex: ☐M ☐F Client/PT. Tell. No: _____

Family /Friend name: _____ Tell no: _____

Health Facility/Organization referred to: _____District: _____ Region: _____

Reason for referral:

_____

Brief History:

Date of HIV test confirmed: _____ Date enrolled to Care: _____

Clinical Stage: _____ Weight: _____ kg: Height: _____ Functioning status: _____

Baseline CD4 counts: _____&_____% Date test done: _____

Currently on HAART ☐ Yes ☐No: *(if yes complete all information below)*

Date ART started: _____1st Line Started Regimen: _____

Base line Viral Load _____ Date test done: _____

CURRENT (ART) STATUS

Last visit date: _____ Weight: _____Kg Height (children): _____cm

Last CD4 Count: _____ & _____% Date test done: _____ TX. Clinical staging: _____

Last Viral load (if available): _____ Date test done: _____

Latest Function: _____ Current regimen: _____

Any Substitutes made? ☐ Yes ☐ No *If yes provide relevant information below*

1ST Substitution: _____ Date: ____/_____/_____ reason: _____

2ND Substitution: _____ Date: ____/____/_____ __reason: _____

Second line regimen: _____ Date: _____/_____/____ reason: _____

1ST Substitution: _____ Date: ____/_____/_____ reason: _____

2ND Substitution: _____ Date: ____/____/_____ reason: _____

THIRD LINE /SALVAGE REGIMEN:_____Commend: _____

Currently on TB /Leprosy TX: ☐ Yes ☐ No Date started: ____/_____/____Date Stopped: _____

Currently on CTX/Dapsone: ☐ Yes ☐ No Date started: _____/____/_____ Date stopped: _____

Currently on INH: ☐ Yes ☐ No Date started: ____/____/_____ Date stopped: _____

If not on abovementioned Prophylaxis /TB Treatment: Comments: _____

_____

Other concomitant medicines: _____

Drug allergies if any:_____

Currently Pregnant: ☐ Yes No ☐ if yes, LNMP: _____ EDD: _____

Name, Surname of Referring Officer:_____ Title: _____

Date Referred: _____ Telephone number: _____

E-mail address: _____ Signature: _____

----------Tear or cut here ----------

PART B

NOTE: PLEASE SEND SLIP BACK TO REFERRING HEALTH FACILITY WITHIN 4 WEEKS

Receiving Health Facility: _____District:_____ Region: _____

Tel: _____ Fax no: _____ E-mail:_____

Patient/Client name: _____ Unique number: _____

Comment on service provided: _____
_____

Name, Surname of service provider:_____ Title: _____

Signature: _____ Date service rendered: _____

Annex B: Referral Register

REPUBLIC OF NAMIBIA
MINISTRY OF HEALTH AND SOCIAL SERVICES

Date (referred or received)
Reg. No/ Unique number
Full Names and surname
Date of birth
Age
Sex (M/F)
Marital status (M/D/S)
Physical Address
Contact details: Telephone number
Next of kin/Friend:(name, surname and contact details)
Ref erred to (Name of facility/department patient send to)
Received from (name of health facility or department patient coming from)
Reason for referral / Service required
Feedback received (Yes or No)
Remarks (e.g. service provided or reason not reached destination)
Name and surname for the Referring/Receiving staff

Annex C: Bi-Directional Referrals Monthly Summary Report Form

REPUBLIC OF NAMIBIA

MINISTRY OF HEALTH AND SOCIAL SERVICES

Region…… District…….…… Facility/Department: ……. Telephone/email: …… Reporting Month: ……..

A.	Number of patients/clients referred to other facilities		
B.	Number of clients/patients received from other facilities		
	Total number of referrals (received plus referred out)		
	Services referred for/Provided	**Referred out**	**Received in**
1	ART		
2	PEP		
3	TB		
4	Nutritional support		
5	Psycho-social support		
6	Male Circumcision		
7	Mental Disorders		
8	emergency cases (specify)		
9	Home based/Palliative Care		
10	**Other (specify)**		
	• • •		
	Number of patients not received required services (please state reasons)		
	Total number of patients followed up and not traced (please state reasons)		

Compiled by: Name and Surname: _____ Title: _____

Signature: _____ Date: _____

Annex C: Patient Referral Form (9-1 0085)

REPUBLIC OF NAMIBIA
MINISTRY OF HEALTH AND SOCIAL SERVICES

Region: _____ **District:** _____ **H. Facility:** _____

Referral to: (name of H. Facility):_____ Ward/Unit: _____

Client/PT. Surname: _____ First Names: _____

Reg. No. _____ Date of Birth: ____/_____/_____ Age: _____ Sex: ☐M ☐F

Physical address: _____ Client/PT. Tell. No: _____

Family/Friend Name & Surname: _____ Contact Details: _____

Patient clinical data

Brief History:
_____

Clinical findings on Physical examination:
_____
___

Provisional Diagnosis:
_____
__**Management (i**nvestigations and treatment)
_____
_____

Reasons for referral:
_____

Any additional relevant information (e.g. psychosocial issues):

_____

Name and surname of referring HCW: _____ Title: _____

Cell No: _____ Facility Tell. No.: _____ Fax: _____

Signature: _____ Date: _____ Time: _____

.....Tear or cut here.....

PART C: Feedback receipt: (*Fill in and give to patient to take back to the referring site)*

Patient Name and Surname: _____ Age: _____ Sex: _____

Reg. No.: _____ Admission date: ___/____/_____ Discharge date: ___/ __/_____

Final Diagnosis: _____

Procedure/Treatment details:

_____

Discharge Treatment:

_____

Special instruction/Follow-up

_____

Name of Doctor_____ Contact details: Tel/Email/Cell: _____

Hospital/H. Facility: _____ Ward/Unit: _____

Signature: _____ Date: ___/_____/_____

Annex D: Tuberculosis Patient Transfer Form

Republic of Namibia

Ministry of Health and Social Services

National Tuberculosis and Leprosy Programme

Name of Transferring Health

Facility:_____**District:**_____

Tel / Fax No:_____

Name of Receiving Health Facility:_____ **District:**_____

Tel / Fax No:_____

Name of patient:_____ **Registration No:** _____

Age:_____ **Sex:**_____**(_F/M_)**

Diagnostic category (tick one): New/previously treated (Treatment after failure/default/relapse)/other/ TI

Date treatment started: _____ **Expected completion date:**_____

Regimen:	**Initial phase (Tick)**	**Relevant F/U smear dates and results**	**Continuation phase (Tick)**	**Relevant F/U smear dates and results**
New patient: 2RHZE/4RHE				
Retreatment: 2RHZES/1RHZE/5RHE				

MEDICINES AND NUMBER OF TABLETS

Anti-TB Medicines	**No. of tablets**	**Anti-TB Medicines**	**No. of tablets**
4-FDC [RHZE] Adult		Streptomycin injection (dose)	
3-FDC[RHE] Adult		Other:	
2-FDC [RH] Adult		Other:	
3-FDC [RHZ] Child		Other:	
2-FDC [RH] Child		Other:	
Pyridoxine 25mg/100mg		Other:	
Co-trimoxazole 480mg		Other:	
ART		Other:	

Health Worker Name/Title:_____

Signature:_____ **Date Transferred:**_____

NOTE: PLEASE CUT-OFF HERE AND SEND SLIP BACK TO TRANSFERRING HEALTH FACILITY AFTER YOU HAVE RECORDED PATIENT'S TREATMENT OUTCOME

Tel/Fax No: _____

Patient Name:_____ Reg. No. at Receiving Health Facility:_____

Your patient was received here on (date):_____ Treatment outcome (date + result):_____

Health Workers Name / Title: _____ Signature: _____

Annex E: Community and Home Based Care Referral Form

Republic of Namibia

Ministry of Health and Social Services

FOR CHBC PROVIDER TO FILL OUT AND GIVE TO CLIENT/ CAREGIVER TO TAKE TO THE SERVICE PROVIDER

Date: _____ Referred by:_____

Address of person making referral:_____

Name of Client: _____

Date of Birth:_____Sex:_____

Does client/ caregiver consent to be referred (client signs or puts a cross):_____

Client referred to: _____

Referred for/to (tick all that apply):

_____ Medical care
_____ VCT
_____ TB screening/ treatment
_____ Legal support
_____ ARVs
_____ Psychosocial support
_____ Social grants
_____ School fee exemption application
_____ Other (specify)

_____ Woman and Child Protection Unit
_____ ANC/PMTCT
_____ Condoms and/or family planning
_____ Youth-friendly services
_____ Support group
_____ Nutrition support
_____ Partner and/or child follow-up
_____Opportunistic infection (specify)_

_____

Signature (person referring):_____

----------Tear or cut here----------

FOR THE SERVICE PROVIDER TO FILL OUT AND GIVE BACK TO THE CLIENT, WHO CAN THEN SHARE IT WITH THE CHBC PROVIDER

Date: _____ Name of Facility/ Service provider: _____
Name of Client: _____
Remarks: _____
_____
Service given: _____
Follow up (e.g., home care, revisits): _____
Date of Next Visit: _____
Name of Service Provider: _____ Designation of Service Provider:_____
Signature: _____

[4] *Adapted from Community Home-Based Care for People and Communities Affected by HIV/AIDS: A Handbook for Community Health Workers*

by Pathfinder International

GLOSSARY

Community Home Based Care (CHBC): Is the holistic, comprehensive care of clients that are extended from the health facility to the client's home through family participation and community involvement within available resources and in collaboration with health workers. It encompasses clinic care, nursing care, palliative care counseling and psycho-spiritual care and social support.

Community Health Care Provider: Are volunteers who make a significant contribution to CHBC within this larger group. They visit homes and support and provide palliative care to people with chronic illnesses and their families.

Health Facility: Are facilities that provide health care, they include hospitals, health centers, clinics, and specialized care centers, such as maternity centers and psychiatric care centers.

Continuum of Care: Describes the delivery of health care over a period of time. In patients with a disease, this covers all phases of illness from diagnosis to the end of life.

Primary Health Care Provider: Refers to a health care worker/provider who comes first in contact with the patient/client that needs further referral.

Catchment area: Refers to the geographical area and population served by an institution, e.g district hospital may cover a defined district, while a PHC clinic may only cover a constituency

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