## A. CLIENTS SHOULD BE INFORMED THAT THE TREATMENT OR FOLLOW UP OF THE FOLLOWING SPECIAL CONDITIONS ARE AVAILABLE BY REFERRAL OR ON SITE:

1. Medical problems beyond the scope of the treatment facility.
2. Positive Chlamydia or GC tests and/or other **STI**. Primary or secondary syphilis may be treated at a family planning facility, if it is set up to do so. Other stages of the disease should be referred for further diagnosis and treatment.
3. Cervicitis, vaginitis, and minor gynecologic problems.
4. Positive or suspicious cervical cytology.
5. Hemoglobinopathies (e.g., sickle cell).
6. Positive tuberculin tests.
7. Pregnancy related services, when appropriate, including testing and counseling.
8. Sexual dysfunction and human sexuality counseling.
9. Infertility work-up and/or therapy of an extensive nature.
10. Clients or partners of clients requesting information about, and/or operation for, sterilization, if that service is not available on site.
11. Genetic counseling.
12. Social casework not appropriately handled by project personnel.
13. Sexually transmitted **infection** counseling, including AIDS, HIV positive referrals or counseling inquiries.
14. Natural family planning counseling.
15. Nutrition counseling.
16. **Healthy Communities** case management services, **formerly** Early and Periodic Screening, Diagnosis, and Treatment (EPSDT), for Medicaid eligible clients twenty years of age or younger, Medicaid eligible children of clients, **and pregnant women at any age.**

## B. IN-PATIENT SERVICES

1. The program must maintain a liaison with hospital backup facilities.
2. Either directly or by referral, the program must maintain a referral mechanism for hospitalization of clients with complications arising from contraceptive methods.

## C. GENERAL REFERRAL POLICY

1. Every client has the right to elect or refuse treatment.
2. If during the examination, conditions are found which indicate that further treatment is necessary, the condition shall be fully explained to the client. When possible up to three referral provider options shall be given.

## D. REFERRAL SERVICES

Each delegate must have, by prior arrangement, agencies, physicians, and hospitals to which clients may be referred for the reasons listed below. A written list of referral services should be maintained and updated annually. It is recommended that this list be dated so it is easy to tell

when it was last updated.

1. Problems noted at the time of the history-taking, physical exam, or laboratory testing.
2. Problems arising because of the contraceptive method.
3. In cases where unrelated medical complications arise that are considered outside the domain of the clinic, the client shall be referred to an appropriate physician or hospital.
4. Clients requesting additional referrals to other providers.
5. **Healthy Communities**, formerly EPSDT, for Medicaid eligible clients 20 years of age or younger, Medicaid eligible children of clients **and all pregnant women**. A list of **Healthy Communities** Outreach and Case Management locations is available on CDPHE's Family Planning Program web page. **Healthy Communities** brochures are available from the local **Healthy Communities** case management location: **http://www.colorado.gov/cs/Satellite?c=Page&cid=1218622604254&pagename=HCPF%2FHCPFLayout**

## E. SERVICES FOR SPECIAL POPULATIONS

1. Physically/Developmentally disabled:
   a. Services provided by the agency must be in compliance with ADA regulations.
   b. It is up to the staff to develop sensitivity to the needs of this population.
2. Minors:
   a. Minors requesting family planning services must be encouraged, whenever possible, to consult with their parents with respect to family planning services.
   b. However, services must not be denied where this is not possible.

## F. GENERAL FOLLOW-UP POLICY

1. This program has a responsibility to follow-up in any situation that may be, or is known to be, life- or health-threatening.
2. Follow-up measures are directed towards informing the client about her/his health risks and providing the client with appropriate referral sources for treatment/resolution.
3. A written referral shall be provided to the client. This information shall include recommendations of the clinic.
4. Informing a client she/he is at risk:
   a. When information (Pap or other lab test) is received indicating a client is at risk and the client is not in the clinic. All attempts to contact a client should be made with regard for the confidentiality of the client, whether by phone or letter.
   b. Attempts to contact the client may be made by phone or mail, with all attempts documented in the chart. Use of certified letters with "Return Receipt Requested" early in the course of follow-up can expedite the notification process.
   c. Referrals for conditions which are not urgent or life-threatening require written documentation in the chart noting that the client is aware of her/his need for follow-up, i.e., the return receipt of a certified letter or a note in the client's handwriting.
   d. Urgent or potentially life-threatening conditions require on-going attempts to assure follow-

up.

## G. REFERRAL

1. Internal - The client may be asked to return to the **family planning** clinic at a later date for further evaluation or follow-up. Documentation should be made in the chart, including the time frame for and purpose of this return visit.
2. The request to return shall be logged in whatever manner is usual in the local clinic, and the log will be checked at intervals to assure that persons asked to return to clinic have done so.
3. External - If the client is referred to an outside agency or health care provider, the client shall be given a referral form that identifies the reason for the referral. Client shall give consent for transfer of medical records as indicated.
4. The referral shall be logged in whatever manner is usual in the local clinic, and the log will be checked at intervals appropriate to the nature of the referral to assure that the clients have obtained further care. The name may be checked off if and when the return copy of the referral is received.
5. Clinics must develop/have in place a **written** mechanism for tracking all internal and external referrals. Time frames for referral follow-up are dependent upon the urgency of the client's problem. Agency policy should address time frames for follow-up. Suggested time frames can be found at the end of this policy. (See Title X [Federal] Program Guidelines, Part II, 7.4)
6. When follow-up reports are returned to the program, they will be checked off on the log, reviewed and initialed by the provider, and filed in the client's chart.

## H. PROVISION OF SERVICES TO CLIENTS REFERRED FOR FOLLOW-UP CARE:

1. Any client for whom follow-up care has been requested MUST have written follow-up information from the physician providing care in order for the program to continue providing services. All attempts to obtain this follow-up information must be documented in the client's chart. When clients fail to obtain the indicated follow-up or the clinic is unable to obtain the documentation of the follow-up care, the decision to provide ongoing care should include consideration of the risk to the client (unintended pregnancy from loss of contraceptive services) vs. the risk to the agency (liability claims).
2. This applies especially to situations in which ongoing provision of services (i.e., hormonal birth control methods or IUD) may result in aggravation of the condition for which the client has been referred.

## I. FINANCIAL RESPONSIBILITY FOR REFERRALS

1. Referrals for required Family Planning services through an outside contractor, such as IUD or Implanon® insertions, must be provided on the sliding fee scale developed by the agency and approved by the Administrative Consultant at CDPHE.
2. Sterilizations, whether provided by referral or on site, and funded through the Colorado Family Planning Initiative, must be provided at no charge to the client.
3. Referrals for non-required services (including but limited to such services as colposcopy, HIV testing, hypertension evaluation) or for complications resulting from procedures or medications provided by the program are the financial responsibility of the client. The delegate agency is not expected to assume part or all of this financial liability. It is recommended that the delegate agency help the client identify available resources.

*The following is a sample of a Referral Form. This form can be downloaded from the* ***CDPHE Family Planning Program*** *website at:*
*http://www.cdphe.state.co.us/pp/womens/FPNursingConsntsForms.html.*

## REFERRAL FORM

**DATE** _____ **REFERRING AGENCY** _____

**NAME**_____ **BIRTHDATE** _____

**Family Planning Program staff will offer you up to three choices of referrals whenever possible.**

**REFERRED TO:**

1. _____
*Name* *Address* *Telephone*

2. _____
*Name* *Address* *Telephone*

3. _____
*Name* *Address* *Telephone*

**REASON FOR REFERRAL:**

_____
**Staff signature** **Date**

==========
**REFERRAL AGENCY/STAFF PHYSICIAN**:
Please return one copy to the referring agency and keep one copy for your records.

THANK YOU!
==========
**SUMMARY OF FINDINGS:**

_____
**Provider signature** **Date**

SAMPLE

*The following is a sample of a Follow Up Form. This form can be downloaded from the* ***CDPHE Family Planning Program*** *website at:*
*http://www.cdphe.state.co.us/pp/womens/FPNursingConsntsForms.html.*

**INTENT TO SEEK FOLLOW UP FORM**

On _____ I was advised that I should seek follow-up medical care
***Date***

for _____.

❑ **I have decided to obtain further medical care from:**

Doctor or clinic: _____

Address: _____

❑ **I have decided <u>not</u> to obtain follow-up. I understand the reason the follow-up is recommended.**

My reason for not obtaining follow-up is: _____

Please enter this information in my files.

_____
**Patient signature** **Date**

SAMPLE

*The following is a sample of a Referral Feedback Form. This form can be downloaded from the* ***CDPHE Family Planning Program*** *website at:*
*http://www.cdphe.state.co.us/pp/womens/FPNursingConsntsForms.html.*

## REFERRAL FEEDBACK FORM

We would appreciate feedback on the referral that we gave you. Your response will be kept confidential, and if you have any specific complaints or concerns about the referral, please speak to one of the staff.

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I. Name of the physician or agency you visited:

2. What was the purpose of the referral?

3. Did you have any difficulty getting an appointment? If so, please comment.

4. Were the fees for the services provided acceptable and affordable? If not, please explain.

5. Were you satisfied with the care provided by the staff/physician? ____ Yes ____ No
If not, please explain:

Were all of your questions answered?____ Yes ___ No Comments:

6. Would you like someone on the family planning staff to contact the referral regarding any of your comments?____ Yes ___ No Other comments or suggestions:

DATE:

NAME (OPTIONAL)

SAMPLE

## EXAMPLES OF TIME FRAMES FOR REFERRAL AND FOLLOW UP POLICIES

This is an example of how to set up time frames for referral and follow up of abnormal findings.

1. Emergency – follow up in 12-48 hours or sooner, some examples are:
    a. Possible ectopic
    b. Severe PID
    c. Complicated GC/CT
    d. Malignant hypertension
    e. Severe UTI or pyelonephritis

2. Urgent – follow up within 2-4 weeks or sooner, some examples are:
    a. Initial episode of herpes
    b. Solitary breast nodule, depending on risk factors
    c. Hypertension
    d. Positive GC/CT or other screening for infections

3. Essential – follow up in 1-2 months or sooner, some examples are:
    a. Hematocrit above 55% on repeat, or anemia after trying increased iron
    b. Hypertension
    c. Abnormal Pap
    d. Enlarged thyroid
    e. Solitary breast nodule, low risk for cancer

4. Discretionary – referrals made at the request of the client, follow up at the next clinic visit. Further follow up may not be necessary, but should be based on professional judgment.