UNION TERRITORY OF JAMMU & KASHMIR
DIRECTORATE OF HEALTH SERVICES, JAMMU
Near MLA Hostel, Indira Chowk Jammu, J&K Pin: 180001
E-mail: dhsjammu@rediffmail.com, dhsjammu@gmail.com
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Referral Protocol

1. Every referral from any of the peripheral institutions whether emergency or non-emergent will be entered in the Referral Register and the serial number of entry will be mentioned on the referral slip.

2. All the referrals will mandatorily carry a referral slip counter signed by the Consultant in the specialty from which referral has originated or from the Medical Superintendent/Block Medical Officer or Incharge Medical Officer only in emergency cases and the date/time, origin of referral, condition of patient, reasons for referral shall be recorded under the sign and stamp of the officer incharge:
   i. Incharge Medical officer (in emergency situations only) or,
   ii. Consultant of the concerned specialty, or
   iii. Medical Superintendent, or
   iv. Block Medical Officer.

3. The referrals shall be made strictly as per the clinical protocols that are applicable for each individual case. Even in case of emergencies, due validation of the referral from the concerned specialist be ensured and entered in the Referral Register and communicated to the concerned Chief Medical Officer and the Nodal Officer at the Directorate of Health. In case of a patient requiring direct referrals to tertiary care hospital from any of the PHCs or CHCs, the Doctor assessing the patient in the first instance, should also consider the time required to follow regular referral chain vis a vis the patient's clinical condition so that timely and appropriate management of the case at the appropriate facility is ensured.

4. For referrals originating at the levels of Primary Health Centers/NTPHCs, the destination shall not exceed District Hospital except for the conditions of Emergencies wherein the mechanism described above shall operate.

5. The referral chain of the Directorate of Health Services, Jammu will be as under: Sub Center (SC)/New Type Primary Health Center (NTPHC) -> Primary Health Center (PHC) -> Sub District Hospital (SDH)/Community Health Center (CHC) -> District Hospital (DH)/Maternity Hospital.

6. The Chief Medical Officer shall monitor referrals in their respective districts including District Hospitals on a daily basis and shall submit day wise weekly reports to the Directorate of Health Services, Jammu.

7. The Referrals henceforth shall be made only after filling the Patient Referral Form as attached herewith. The same will be used as a referral slip and a counterfoil will be kept at the referring hospital for record and audit.

8. Patients request referrals on their own, must be counseled due to the rush at the tertiary care hospitals. In case, the patient still insists, a written request must be sought from the attendant accompanying the patient who should then be kept as record.

9. The Chief Medical Officers shall ensure District Hospitals/MCH provide 24x7 theatre facilities and in no way shall this service be stopped due transfers/leaves. Proper arrangements must be made to this effect by way of internal adjustment within the district.

10. In case of a patient whose clinical condition might deteriorate during transfer, the patient must be accompanied by atleast one Medical personnel all the way to the tertiary care hospital. In case, the transfer is being done in the Critical Care Ambulance, patient record in the prescribed format (copy enclosed) will be maintained.

11. The records/entries in the Referral Register must corroborate with the all other relevant records including JSSK/JSY/Ambulance log etc.

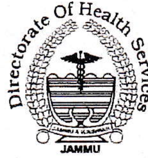
12. The Referral Control Room already established at Division of Epidemiology and Public Health, __________ shall collect the Referral data from the Districts as per the past practice.

13. The Referral Control Room will also periodically seek records from the tertiary care hospitals and will be the mechanism of the audit of referrals from the peripheral hospitals. For this purpose, services of concerned specialists in various specialties may be sought and the reports thus generated will be shared with the Directorate.

Follow up

Enclosures: [02 leaves]

(Dr. Saleem Ur Rehman)
Director Health Services,
Jammu



DIRECTORATE OF HEALTH SERVICES, JAMMU
REFERRAL PATIENT LOG

Patient Name: ______________________ Address: ______________________________

Phone no: ______________ Attendant Name and Contact: ______________________________

Sex: ________

Provisional Diagnosis

____

____

____

____

Reasons for Referral: ____________________

____

____

____

Name of Referring Hospital: ________________

MRD registration No: ________________

Phone no. of the Referring Hospital: ____________

Referring Doctor: ____________________

Referral Date and Time: ________________

Receiving Hospital Informed: YES ______ NO ______

Signature of referring doctor: ______________

Referring Doctor Mobile No: ______________

Summary of Presentation:

History:

Patient Received in ambulance by

Name: ____________________________

Designation: ________________________

Date and Time: ______________________

Phone Number: ______________________

Relevant Physical Examination:

Investigations:

Treatment Provided:

Referral Hospital Details:

Name of the Hospital: ____________________

Receiving Doctor: ______________________

Receiving Date and Time: ________________

____

DIRECTORATE OF HEALTH SERVICES, JAMMU
CRITICAL CARE AMBULANCES
PATIENT LOG

Patient Name: ____________________ Address: ____

Phone No: ______________ Attendant Name and Contact: ____

Sex: ________

Primary Diagnosis:

____

____

Name of Referring Hospital: ________________

Referring Doctor: ________________

Referral Date and Time: ________________

Receiving Hospital Informed: YES ______ NO ______

Signature of referring doctor: ________________

Co-Morbidities (circle all existing or past condition):

Heart Disease: Stroke: Hypertension: Lung Disease: Kidney Disease:

Diabetes: Substance Abuse:

Regular Medication if any: ________________

Allergies if any: ______________________

Weight: ________ Height: ______ BMI: ______

BLOOD GROUP:

Vital Signs	Pre-Transport (To be filled by Referring Doctor)	20 Min (To be filled by Ambulance Staff)	40 Min (To be filled by Ambulance Staff)	60 Min (To be filled by Ambulance Staff)	Post-Transport (To be filled by Receiving Doctor)
Time					
HR/Rhythm					
BP					
PAP					
Vent Mode					
PEEP/PS					
RR					
Tidal Volume					
Minute Volume					
Sp02					
ETCo2					
GCS					
Pupil L/R					
Revised trauma Score					

Patient Received in ambulance by

Name: ________________

Designation: ________________

Date and Time: ________________

Phone Number: ________________

RECORDED EVENTS IN THE AMBULANCE

S.No.	Event	Time
1		
2		
3		
4		
5		
6		

S.No.	Intervention/Treatment given	Time
1		
2		
3		
4		
5		
6		

Use additional separate sheet if required

Patient handed over to

Receiving Doctor: ________________

Receiving Date and Time: ________

Signature of receiving doctor: ________

Signature of Medical provider