MAP – Guidance for Criterion 5: Urgent referrals to secondary care

This criterion for details of five cases you have seen, assessed and sent for urgent assessment by secondary care colleagues. Admission to hospital is not always the outcome, and this result may be entirely appropriate.

Carefully read the guidelines and fill in all the boxes with appropriate details in the proforma.

You need to present assessors with a clear idea of the patient’s presenting complaint, findings on examination (detail clearly ALL findings including general impressions and specific recordings appropriate for each patient complaint), and the exact reasons why you decided to refer then and there to secondary care. Remember to tell us about the patient’s social circumstances, and how you communicated with relatives / carers.

You will need to know the outcome of the referral, so if you include a patient seen in an out-of-hours setting, for example, you still need to find out the outcome. If you would not normally track the outcome, you would need to do so for each of these five patients.

This criterion asks for a copy of the patient record, which is the entry you make in the patient’s medical record. Scan or retype this into the appropriate box on the proforma. You do not need to include a full copy of the referral letter to the hospital.

You should give clear information your patients in your own words. The cases do not need to be consecutive and we suggest you select five referrals that have been seen within the last year, thoroughly and competently assessed by yourself, and referred appropriately with a known outcome.