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Approval Process

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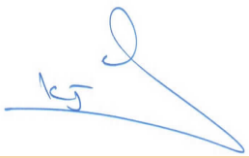
Approved by	Dr.Kadhim Jaffar Sulaiman	DG of DGSMC	Ministry of Health	December 2021	

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Acronyms

CPR	Cardiopulmonary Resuscitation
DGIT	Directorate General of Information Technology
DGMS	Directorate General of Medical Supplies
DGQAC	Directorate General of Quality Assurance Centre
ED	Emergency Department
ICU	Intensive Care Unit
IRLS	Incident Reporting & Learning System
KPIs	Key Performance Indicators
MoH	Ministry of Health
MRD	Medical Records Department
MRI	Magnetic Resonance Imaging
NBU	National Burn Unit
OPD	Outpatient Department
PHC	Primary Health Care
SMS	Short Message Service
SOPs	Standard Operating Procedures

Acknowledgement

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Procedures of Patient Referral

1. Introduction

The healthcare system in Oman is designed in a way that ensures continuity of patient care across the different levels of the health system. It is also supported by several coordination mechanisms that assure harmonious performance among the various system units. One of these mechanisms is the patient referral system which connects the three levels of healthcare and assists in making the use of the scarce and valuable healthcare resources more efficient.

This document will elaborate on the different components of the referral system and address all issues related to the referral process in order to establish a common referral practice among all ministry of health institutions; aiming eventually for a more effective and efficient healthcare system. The procedures stated in this document should be used in conjunction with any complementary or additional policies or guidelines addressing patient referral.

2. Objectives

2.1 To unify the procedures of patient referral among all MoH healthcare institutions.

2.2 To ensure continuity of patient care at the different levels of health care.

2.3 To ensure patient's safety during the process of patient referral.

2.4 To improve the communication between referring and referred healthcare facilities in relation to patient referral.

2.5 To improve the quality of the referral process and referral feedback.

3. Scope

These procedures are applicable to:

3.1 All Ministry of Health (MoH) hospitals, polyclinics and health centres.

3.2 All governmental non-MoH institutions and private health facilities when referring patients to or receiving patients from MoH institutions.

4. Definitions

4.1 Patient referral: the process of transferring patient's care from one health care facility to another whether at the same level of care or another level.

4.2 Healthcare institution/facility: any hospital, specialized polyclinic, health centre, or clinic.

4.3 Referring institution/facility: the healthcare institution/facility that initiates the process of patient referral or transfer.

4.4 Referred institution/facility: the healthcare institution/facility that receives the referred or transferred patient.

4.5 Back-referring institution/facility: the healthcare institution/facility that refers or transfers back a patient who was initially referred/transferred to it from another healthcare institution. The back referral can be to the initial referring institution or to another appropriate healthcare facility.

4.6 Back-referred institution/facility: the healthcare institution/facility to which the patient is being back referred or transferred.

4.7 Emergency referral: a referral for conditions that require immediate evaluation and treatment to prevent mortality or increased morbidity e.g. life-threatening conditions, conditions with major organ dysfunction, conditions that involve risk of vision or limb loss, etc.

4.8 Urgent referral: a referral that requires sooner consultation or management by a higher level healthcare facility or specialization.

4.9 Routine referral: a referral for condition that involves no threat to life or organ function, and where the normal expected delay in evaluation or management will not lead to mortality or increased morbidity, neither will negatively impact the patient's long term prognosis.

4.10 Inappropriate referral: a referral which is either unjustified, misdirected, or contains insufficient clinical information

4.11 Unjustified referral: a referral which has no valid medical reason for referral.

4.12 Misdirected referral: a referral which is directed to an institution or department/speciality that does not have or deal with the required service.

4.13 Referral with insufficient clinical information: a referral which lacks the necessary clinical details that justify and explain the medical grounds for the referral.

4.14 Appropriate referral: a referral that is neither misdirected nor unjustified, and contains all necessary clinical details.

4.15 Primary health care (PHC): the level of care which is responsible for providing the basic therapeutic, preventative, promotive and rehabilitative health services for individuals and their families. In MoH, primary healthcare services are provided mainly by health centres, extended health centres, and local hospitals.

4.16 Secondary health care: the level of care which is responsible for providing specialised diagnostic and therapeutic services that focus on specific organs or diseases. People often come in contact with secondary care specialists through referrals from primary care providers. In MoH, secondary health care services are provided by the specialized polyclinics, Wilayat hospitals, and the regional referral hospitals in the different governorates.

4.17 Tertiary health care: this level of care is also responsible for providing specialised diagnostic and therapeutic services but it gives more focus on subspecialised services and it uses more

advanced diagnostic and treatment technologies. In MoH, tertiary healthcare services are provided by four hospitals: Royal Hospital, Khoula Hospital, Al-Nahdah Hospital, and Al-Masarra Hospital. For the population of Muscat Governorate, these hospitals also serve as secondary healthcare providers.

4.18 Regional hospital: a hospital that provides secondary or tertiary healthcare to inhabitants of the health region where it is located. The regional hospital is considered as the referral hospital for patients from other hospitals and health centres of that health region. Most regional hospitals are supported by extended health centres or specialised polyclinics that provide secondary outpatient services in addition to some primary healthcare services. Regional hospitals have all the main clinical specialties and they are equipped with the necessary equipment, drugs, consumables, and ancillary services that enable them to fulfil the healthcare needs of patients within the boundaries of that region. Regional hospitals in Muscat Governorate (Royal Hospital, Al-Nahdha Hospital, Khoula Hospital, and Al-Masarra Hospital) serve as secondary and tertiary healthcare providers for the population of Muscat Governorate, and as tertiary care hospitals for patients referred from other regional hospitals.

4.19 Wilayat hospital (hospital at department level): a hospital that provides secondary health services and occasionally some primary care services to the inhabitants of the Wilayat where it is located and sometimes the inhabitants of nearby Wilayats.

4.20 Local hospital: a small hospital that provides primary healthcare services to inhabitants of the nearby villages, as well as inpatient services to patients who need continuous medical observation and/or care.

4.21 Health centre: a local health facility that provides primary health care services to people in the surrounding catchment area.

4.22 Extended health centre (conventionally called polyclinic): a health centre that provides primary healthcare services and at the same time has some specialized outpatient clinics that provide secondary health services. Extended health centres serve people in their catchment area as well as people referred from other health centres in the same health region.

4.23 Specialized polyclinic: a health facility that provides specialized outpatient services to the inhabitants of its catchment area. Currently, only Bawshar and Al-Seeb polyclinics are classified as specialized polyclinics.

4.24 Virtual clinic: the term virtual clinic can have different meanings. However, in this document it refers to a planned contact between the patient and the referred doctor through one of the communication technologies for the purpose of clinical consultation and advice.

4.25 Healthcare provider network: the list of health facilities which contracted with the insurance company to provide health care to the insured person according to the health insurance plan.

5. Procedures

5.1 General rules

5.1.1 Once approved, this document will replace all previous procedures and guidelines related to patient referral. Any local or national documents addressing issues related to the referral process have to be modified to conform to the procedures stated in this document.

5.1.2 The patient referral procedures described in this document are applicable only to referrals between healthcare institutions, not within the same institution (inter-departmental referral) where each healthcare facility can implement its own regulations.

5.1.3 Generally, MoH procedures of patient referral are also applicable to referrals from and to private healthcare facilities non-MoH governmental healthcare institutions (e.g. Sultan Qaboos University Hospital, Royal Oman Police Hospital, Armed Forces Medical Services, Diwan Medical Services). However, the local regulations of these healthcare facilities should always be observed and respected.

5.1.4 As a general rule, patients/clients have to access the health system through primary healthcare facilities at the community level; secondary and tertiary hospitals should implement the necessary rules and regulations to prevent direct access to their services. Exception to this rule are emergency cases where patients can access the hospital care directly, and also situations where there are special regulations at the governorate level allowing direct access to hospital services.

5.1.5 Patients who are found to be in-need for specialized consultation, investigation, or treatment, or who require care that cannot be provided at the current level of healthcare have to be referred to a specialist or institution that can provide that type of care. That means, patients should be referred from one healthcare facility to another only if the required service or resources necessary for patient care is not available at the referring institution.

5.1.6 Expatriate patients who are ineligible for free health services in public health institutions have to be referred/back-referred to private sector health facilities if the required service is available there and the geographical distance to those facilities is acceptable (e.g. within the boundary of same governorate). This rule is applicable to referrals from MoH health institutions, non-MoH governmental

health institutions, and private health facilities. The same is applied to expatriate patients who are eligible for free health services (e.g. government-employed expatriates) but need to be referred for one of the excluded health services (see appendix 1), unless the patient wants to continue the treatment in the public health institution and pay for it.

5.1.7 For expatriate patients who are referred or attend for emergency conditions, all necessary emergency treatment has to be provided. Once the patient is stable, he/she has to be referred to a private facility where the required service is available (if the referral is necessary). Treatment and referral of expatriate patients are detailed in section 5.6.

5.1.8 In general, the referral process has to follow (as much as possible) the hierarchical level of services or referral, and based on the conventional practice. That means, referrals should be routed stepwise from the lower level of care to the higher level. However, for cases where it is clear that the required service is not available in the next level of care or the transfer trip of an emergency case to the next level of care can jeopardize patient's life, bypassing the next level and presenting to a higher level is acceptable. In the same way, back referrals should be routed stepwise from the higher level of care to the lower level. However, if the patient's condition does require the advanced care provided in the next level, bypassing that level and referring the patient to a lower level of care is also acceptable.

5.1.9 Generally, patient referral from one governorate to another should take place through the regional hospitals only.

5.1.10 Local healthcare facilities of each governorate should refer their patients first to the regional hospital of the relevant governorate, including healthcare facilities that belong to other governorates but geographically closer to Muscat Governorate. Exceptions can be considered if it is clear that the required service is not available in the regional hospital or if the patient's condition is critical and the transfer journey to the regional hospital will take longer time than transfer to a tertiary hospital in Muscat, provided that prior arrangements were made with the referred tertiary hospital.

5.1.11 Referred institutions should give special consideration to referral requests from hospitals in remote locations (e.g. Salalah, Musandam); taking into account the issues of travel schedules and logistic arrangements.

5.1.12 Primary healthcare facilities in Muscat Governorate can refer their patients directly to the tertiary care hospitals if the required specialty or service is not available in the specialized polyclinics (Bawshar and Al-Seeb Polyclinics). This exception arises from the absence of distinct secondary care hospitals in Muscat Governorate.

5.1.13 Referral of urgent and routine cases from health centres to non-MoH governmental healthcare institutions is not allowed. It is only polyclinics and hospitals that can refer to these institutions and through booked appointments. However, referral of emergency cases is acceptable but require prior communication with the emergency department or the concerned specialty on-call doctor in those institutions.

5.1.14 Tertiary care hospitals can refer their patients directly to PHC facilities, bypassing the secondary care hospitals if it is clear that the patient will not require specialized care and the required service is available in PHC facilities.

5.1.15 For referrals to Al-Masarra Hospital (the national psychiatric hospital), the general procedures of patient referral applies only to referrals coming from outside Muscat Governorate. However, psychiatric patients in Muscat Governorate should be referred first to Bawshar or Al-Seeb polyclinics if the patient is from the catchment areas of these two institutions, otherwise the patient has to be referred directly to Al-Masarra Hospital.

5.1.16 Direct referral from primary health care institutions to subspecialties in hospitals is permitted only to family physicians and the specialized doctors who run their clinics at PHC. Other doctors in PHC facilities should refer their patients first to the general speciality or to another family physician who can then refer the patient to the subspecialty, if necessary. However, if there are certain arrangements at the governorate level allowing direct referral to the subspecialty from all PHC doctors, then such practice is acceptable.

5.1.17 Doctors in emergency departments (EDs) should endeavour to refer their patients directly to the required subspecialty, whenever it is possible and when the internal regulations of the referred department allow such practice.

5.1.18 Secondary care hospitals should refer emergency cases that require immediate intervention to tertiary care hospitals only, except in situations where there are prior arrangements between two secondary hospitals. In case of bed unavailability, arranging a bed for the patient in another hospital is the

responsibility of the tertiary care hospital and not the referring secondary care hospital.

5.1.19 Bed unavailability at a referred hospital should not be an excuse for rejecting a referred emergency case especially for life-threatening conditions and when it is clear that the required service is not available in the referring institution. Such patients can be received in the emergency department where life-saving treatment can be initiated until a bed is arranged for the patient either in the referred hospital or another hospital.

5.1.20 The referred hospital has the responsibility of arranging an ICU bed for the referred patient if intensive care is required. If the ICU doctor needs more information about the referred case, it is the responsibility of the ICU doctor or the doctor who accepted the referral to call back the referring hospital and get the required information.

5.1.21 Patient condition instability should not be an excuse for a referred hospital not to accept the referral, and the referring hospital/doctor has full responsibility for the transfer of unstable patients.

5.1.22 For trauma cases that require urgent surgical or neurosurgical intervention in Khoula hospital, the referring doctor should contact the trauma team there and not the concerned department. Once the case is accepted, the trauma team will then make all the necessary arrangements for receiving the patient.

5.1.23 When a patient requires a multidisciplinary care and not all specialties are available in the same hospital, the patient should be referred to a hospital that has the specialty which addresses the patient's most urgent problem. The referred hospital will then be responsible for communicating with other hospitals for the required specialties or services.

5.1.24 If a patient is referred to a hospital for a certain procedure (e.g. MRI), the patient has to be registered electronically in the department he/she is referred to, and all procedure's details have to be documented in the patient's record.

5.1.25 If a patient is referred for a procedure and the patient's condition deteriorates during the procedure, the patient has to be managed inside the same hospital (e.g. in the emergency department) until the patient's condition is stabilized. No patient to be discharged or sent back to the referring hospital before ascertaining patient's stability and absence of any risk. Also, if the same scenario happens to a patient who is initially escorted from another hospital for the procedure, the escorting

team has to refuse escorting the patient back until a specialized doctor confirms patient's stability.

5.1.26 If a patient is referred for a procedure that requires signing a consent, the consent has to be obtained in the referred facility, not the referring one. The referring doctor will give only a brief explanation of the procedure and possible risks, and the referred doctor will explain the procedure and its risks in details and then will ask the patient to sign the consent.

5.1.27 For each referral, a referral form has to be filled out. The referral form has to be complete, clear and written in English, and it should include details of the patient's condition, clinical findings, investigation results, treatment given, and the exact reason for referral.

5.1.28 Referring and referred institutions should always communicate electronically (and sometimes verbally as well) to book appointments for patients or to make referral arrangements, where applicable. That means, all referrals and back referrals coming to and going from MoH health institutions have to be electronic (this includes referrals from and to non-MoH governmental health facilities and private health facilities).

5.1.29 For non-urgent referrals, the electronic system will block sending the referral for patients whose files don’t contain the civil ID number. In case the patient's civil ID number is not entered, a message will appear to the referring doctor asking him/her to enter the patient's ID number if it available at the referral time, otherwise the referral will remain pending until the ID number is entered later by the doctor or MRD staff. The civil ID number is important for tacking multiple and duplicate referrals as well as completing the national e-health data repository which will gather the fractured files from the different health institutions into a single unified file.

5.1.30 MoH health institutions should implement an incident reporting system to events of noncompliance to these referral procedures and to communicate the incident reports to the concerned bodies at the regional or central levels.

5.1.31 All healthcare institutions and departments should raise to the concerned bodies in the MoH any issues or challenges related to the process of patient referral in order to find solutions or alternatives.

5.2 Referral categories

5.2.1 Patients have to be referred according to the urgency level of the condition: emergency, urgent, or routine.

5.2.2 If a doctor is not sure about the urgency level of a certain case (e.g. urgent or emergency), the case should be discussed verbally with the relevant speciality to confirm referral urgency.

5.2.3 If a patient does not fit into emergency or urgent referral categories but needs an early appointment based on clinical grounds, the patient can be listed in the "early appointment waiting list" to get an early appointment against any cancelled booking. However, such facilitation should not be misused and any misuse has to be reported.

5.2.4 Emergency referral proceedings (appendix 2):

5.2.4.1 The referring institution should initiate any required emergency treatment.

5.2.4.2 A senior doctor (when available) should evaluate the patient's condition and weigh the benefits versus risks inherent to patient transfer.

5.2.4.3 If the risks of transfer outweigh the benefits, the attending doctor may choose to continue patient’s management in the same institution with the available resources or can accept the risk (based on solid clinical judgement) to transfer the patient.

5.2.4.4 If the attending doctor decides to continue patient's management at the same institution, the risk of transfer versus benefit should be analysed regularly and the decision of patient transfer can be altered based the result of that analysis. Also, if patient management will be continued at the same facility, the treating doctor may consider seeking management advice by phone from a specialized doctor who can also visit the patient (whenever possible) after making the necessary arrangements with the referring doctor. In the latter case, the referring doctor has to refer the patient under the reason "For Local Visit" (see section 5.16). The electronic system will then allow the referred doctor to access the referred patient's file at the referring institution when visiting the patient and will be able to document all clinical information related to patient's condition and procedures done during the visit.

5.2.4.5 If the patient will be transferred, the referring doctor should ensure completion of all referral and transfer arrangements, provided that such procedures will not delay the transfer process. Once these arrangements are completed, the patient should be transferred immediately with a prior telephonic notification to the referred institution.

5.2.4.6 Emergency referrals do not require prior appointment and have to be seen as soon as possible, maximum within 24 hours of referral.

5.2.5 Urgent referral proceedings (appendix 3):

5.2.5.1 All urgent referrals require prior appointments at the referred institution.

5.2.5.2 Urgent referrals have to be seen within 72 hours of receiving the appointment request.

5.2.5.3 If a patient requires an urgent referral for inpatient services, the referring doctor should verbally discuss the appointment matters with the referred speciality, followed by a formal appointment request contains all the details of the patient's condition and the agreed appointment

5.2.5.4 For inpatients, the patient has to be transported to the referred institution by ambulance and with a medical escort team which will be responsible for any referral documents.

5.2.5.5 For outpatients, all referral documents (if not sent electronically) should be handed over to the patient. The patient should arrange his/her own transport to the referred institution, except for referrals from some distant locations e.g. Dhofar and Musandam governorates were the hospital will arrange the patient's transport.

5.2.6 Routine referral proceedings (appendix 4):

5.2.6.1 Whenever resources and capabilities are available at the referring institution, it is always preferred that the referring doctor seeks a management advice from the referred doctor rather than requesting an appointment for the patient.

5.2.6.2 All routine referrals require prior appointments at the referred institution and should be booked for the next available appointment slot.

5.2.6.3 If a routine case requires an early appointment, the referring doctor has to mention this in the referral letter so the patient will be listed in the "early appointment list" to get an early appointment against any cancellation.

5.2.6.4 Other rules and regulations related to referral documents and transport arrangements should remain the same as for urgent referrals.

5.3 Phone consultation

5.3.1 Phone consultation is an acceptable form of seeking guidance on matters related to patient management.

5.3.2 Phone consultations should be carried out, as much as possible, during the normal working hours except for urgent cases where such consultations are acceptable even outside the normal working hours.

5.3.3 When a particular department/speciality seeks a clinical advice through the phone from another hospital, the most senior doctor on duty (whenever possible & applicable) should be on the phone to seek the advice.

5.3.4 When a doctor is consulted through the phone and he/she is unable to give an immediate decision about a case and needs to discuss it with a more senior staff, it is the responsibility of that consulted doctor to call back the consulting doctor once a decision is made and to give a clear and timely management advice about the consulted case.

5.3.5 For emergency cases, it is unacceptable practice of a referred doctor to delay or prevent patient referral and try to diagnose the condition and dictate treatment through the phone, especially when it is clear that the referring institution does not have the required resources to manage the patient.

5.3.6 All phone consultations have to be documented. A formal referral detailing the patient's condition and the advice that was given by the referred doctor has to be sent to the consulted specialty within 24 hours of the event. The referred speciality has to reply back as soon as possible confirming the given advice.

5.4 Referral acceptance/rejection

5.4.1 The referred facility has to respond to each referral within the specified timeframe for that referral category by accepting or rejecting the referral.

5.4.2 Referral acceptance or rejection is decided after evaluating the referral quality by the referred speciality/department. Referral quality falls under one of the following categories: appropriate, unjustified, misdirected, or referral with inadequate clinical information

5.4.3 The electronic system will prevent proceeding in referral acceptance or rejection before evaluating the referral quality. This evaluation is important for monitoring the referral process and improving the quality of future referrals.

5.4.4 Appropriate referral (accepted):

5.4.4.1 Appropriate referrals have to be accepted by the referred speciality/department and given appointments according to the referral category.

5.4.4.2 For each referral, an automated notification about referral acceptance will be sent to the referring facility.

5.4.4.3 If specific requirements are needed from the patient prior to the appointment (e.g. fasting, bowel preparation, etc.), these requirements will be conveyed through the same notification. The referring department/speciality will be responsible for notifying the patient with those requirements.

5.4.5 Referral with inadequate clinical information (provisionally accepted):

5.4.5.1 If a referral is missing some important information about the patient or if the referred doctor wants to know more about the referred patient, then the doctor can provisionally accept the referral until the required information is provided. An automated notification in this matter will be sent to the referring institution.

5.4.5.2 The referring institution should send the required information as soon as possible so the referred institution can proceed in booking an appointment for the patient.

5.4.5.3 The referring facility is responsible for performing any test or procedure needed to provide the required information.

5.4.6 Misdirected referral (redirected or rejected):

5.4.6.1 If a referral is directed to an institution or department that does not have or deal with the required service, then the referred institution can re-send the referral to the correct speciality or institution. However, if the referred institution has doubt about the correct speciality/institution or has no authority to refer to that facility, then the referral has to be rejected with a notification of the reason for rejection.

5.4.6.2 For redirected referrals, the referral feedback will be sent later to the facility which initiated the referral, not the one which redirected it.

5.4.7 Unjustified referral (rejected):

5.4.7.1 Unjustified referrals have to be rejected by the referred facility.

5.4.7.2 The reason for rejection has to be mentioned and it will be sent to the referring institution through an automated notification.

5.4.8 For all rejected cases, SMS notification will be sent to the patient informing him/her about referral rejection and to check/follow up with the referring institution.

5.4.9 Great caution must be taken if an urgent case will be rejected because of the significant impact such rejection may have on patient's safety.

5.4.10 To speed up the process of responding to and accepting of emergency referrals, the Directorate General of Information Technology (DGIT) should work to make it possible for on-call doctors to log into the E-referral platform from remote areas (e.g. home). However, precautions have to be taken to ensure security of patient's medical record.

5.4.11 All referral notifications should be directed to the concerned department/specialty, not to a specific staff. The head of the department/speciality is responsible for setting up some regulations on how to follow up and respond to the referral notifications that reach the department/specialty.

5.4.12 Regulations of referral acceptance and rejection described in this section are also applicable to back referrals. They are also applicable to referrals and back referrals from secondary and tertiary healthcare institutions to PHC facilities.

5.5 Virtual clinic

5.5.1 For some selected non-emergency cases where the referred doctor believes that patient's attendance to the referred institution is unnecessary but viewing the patient is important, the referred doctor may choose to book an appointment for the patient in a virtual clinic, provided that the referral is accepted.

5.5.2 It is only the referred doctor who can decide how the patient's consultation will be conducted: in-person visit or as virtual clinic.

5.5.3 When possible and applicable, virtual clinics are highly advised as they are more cost effective and more convenient to patients, especially patients from remote areas.

5.5.4 Virtual clinics can take place at the referring institution where the referring doctor may act as an intermediary for the consultation, or it may take place while the participants (e.g. referring doctor, referred doctor, patient) are at different locations.

5.5.5 When deciding to give an appointment for a virtual clinic, the referred doctor will choose the type of the virtual clinic based on the need for attendance of the referring doctor or not.

5.5.6 Attendance of the referring doctor is not required:

5.5.6.1 In case where presence of the referring doctor during the consultation is unnecessary, the referred doctor will book an appointment to the patient on a specific date and time. A staff from the referring institution will then communicate with the patient to make the arrangements for the virtual clinic.

5.5.6.2 The medical consultation between the patient and the referred doctor can take place at the referring hospital or while the patient is at home, depending on availability of the communication technology to the patient.

5.5.6.3 Hospitals should consider allocating a specific place for the virtual clinic where patients who do not have the required communication technology at home can use it for the remote consultations. A staff can be assigned to organize the work at the virtual clinic and to assist patients who may have difficulties or language barrier.

5.5.7 Attendance of the referring doctor is required:

5.5.7.1 If attendance of the referring doctor is required during the consultation, the proposed date and time for the virtual clinic will be sent to the referring institution. The system will allow proposing different dates and timings for the clinic in order to make it easier for the referring doctor to select the most convenient date and time.

5.5.7.2 If the referring doctor agrees on one of the proposed dates and time for the clinic, then the request will be confirmed and an appointment will be booked for the patient. The patient will receive SMS notification informing him/her about the virtual clinic and where it will take place. A staff from the referring institution will communicate with the patient to make the arrangements for the virtual clinic.

5.5.7.3 If none of the virtual clinic proposed dates are agreed between the two institutions, the referring doctor may suggest another date and send it to the referred doctor. If no agreement is reached, the referred doctor has to book an appointment for the patient as the usual practice (in-person visit).

5.5.7.4 It is highly advised that the referring and referred specialties have prior arrangements or specified dates for virtual clinics to avoid wasting time to reach an agreement regarding the date for the virtual clinic. It is also advised that a staff is assigned in each hospital to make the necessary arrangements during the day of the virtual clinic to reduce the time that can be wasted during such consultations.

5.5.8 For appointments in virtual clinics, the specified timeframes for giving appointments and responding to appointment requests shall remain the same as appointments in the customary clinics.

5.5.9 For virtual clinics, the electronic system will generate a common platform for both referring and referred institutions where the referring and referred doctors can access patient's file at the same time and enter all clinical information relevant to patient's condition according to the tasks accomplished by each one of them during the consultation (assuming that the referring doctor is involved during the consultation). Each doctor will be able to view the note of the other doctor.

5.5.10 If medications will be prescribed for the patient during the virtual clinic, the referring facility will be responsible for providing these medications if the referring doctor is involved during the consultation. However, if the referring doctor is not involved or if some medications are not available at the referring facility, the referred facility will be responsible for providing the medications and sending them to a nearby health facility where the patient can collect them from there (details of referral medications are explained in section 5.10).

5.5.11 If the referring doctor is not involved in the virtual clinic, feedback of the consultation has to be sent to the referring doctor as explained in section 5.14.

5.6 Treatment and referral of expatriate patients

5.6.1 In general, expatriate patients are ineligible for free treatment in government health institutions. They are also ineligible to be treated in these institutions unless the case is an emergency or the required service is not available in private healthcare facilities (more regulations on provision of health services for expatriates are included in the Ministerial Qarar 99/2021).

5.6.2 Government-employed expatriates are exceptions to this rule as they can receive medical treatment in government health institutions and for free except for some treatments and medications as listed in appendix 1 (based on the civil service council decision No.13/2016).

5.6.3 In the future, if MoH institutions (some or all) become a part of healthcare provider network for certain insurance companies, all expatriate patients who are insured by these companies will be able to access MoH health facilities.

5.6.4 Dealing with expatriate patients who access MoH health institutions for medical care can be guided by two themes: A) service unavailability in private health sector, and B) emergency cases.

5.6.5 A) Service unavailability in private health sector:

5.6.6 If the service is not available in private health facilities, then the patient can attend to MoH health facilities either:

5.6.6.1 directly if it is clear that only MoH health institutions provide that type of service or if the nearest private facility providing that service is very distant (e.g. outside the boundary of the governorate).

5.6.6.2 through an electronic referral from another healthcare facility (MoH, non-MoH governmental, or private healthcare facilities). In this case, all general rules and regulations related to referral and appointment systems should be applied to these patients.

5.6.7 Expatriate patients who receive medical services at MoH institutions will pay the specified charges for the provided services (by insurance, out of pocket, etc.) unless that service is free of charge.

5.6.8 For insured patients who would like to pay through the insurance policy, approval of the insurance company has to be obtained before providing the medical service, provided that the case it not an emergency.

5.6.9 B) Emergency cases:

5.6.10 All expatriate patients who attend with emergency conditions have to be treated and stabilized as much as possible in a way similar to the treatment of other patients.

5.6.11 Further proceedings of care will depend on patient's response to the initial treatment as follow:

5.6.12 The patient improves after the initial treatment:

5.6.12.1 If the patient's condition improves after the initial treatment and no further care or follow up is required, then the patient is discharged home.

5.6.12.2 If the patient's condition improves but the patient will probably require further follow up in the future, then discharge the patient home with a

brief report of the case to follow up at a private health facility of his/her choice.

5.6.12.3 If the patient's condition improves but the patient will require urgent follow up, then the patient is discharged home with a referral letter to a private health facility of his/her choice if the patient does not have health insurance policy, and to a health facility in the healthcare providers network for insured patients. The list of healthcare providers approved for insured patients can be obtained by contacting the concerned insurance company by the PRO. In both cases, selection of the referred facility should always take into account service availability in the referred facility.

5.6.13 The patient does not improve after the initial treatment:

5.6.13.1 If the patient's condition does not improve after the provided initial treatment and the patient requires additional medical services or inpatient care, then the following options have to be considered:

5.6.13.2 If the patient is at one of the PHC institutions, transfer the patient by ambulance to a public hospital at the higher level of care according to the usual referral and transport procedures.

5.6.13.3 If the patient is at a secondary or tertiary healthcare hospital, consider referring the patient to a private health facility that provide the required service otherwise refer to another public hospital where the required service is available or admit the patient at the same hospital especially for critical cases where patient's transport can jeopardize patient's life.

5.6.13.4 If the patient will be referred to a private health facility, then the referral proceedings will be determined by the insurance status of the patient:

5.6.13.5 For uninsured patients, the PRO will present to the patient or patient's attendant a list of the private hospitals that provide the required service to choose from it. It is the responsibility of the patient or attendant to contact the private hospital and arrange for the transfer. However, if patient's transfer cannot be arranged within an acceptable timeframe or the patient is unable to contact the hospital and no attendant is available, then the patient has to be admitted and treated as usual. If transport could be arranged later, then the patient should be transferred otherwise continue patient's treatment in the same hospital.

5.6.13.6 For insured patients, the PRO will contact the insurance company and get the list of private hospitals in the healthcare providers' network of the insured patient. The attending doctor will then compare this list to the list of private hospitals providing the required service and ask the patient choose the private hospital he/she wants to be transferred to. Once a hospital is chosen, the PRO will contact that hospital to inform it about the potential transfer. The referring doctor will also communicate with the referred doctor to discuss the case and arrange for patient's transfer. The private hospital will be responsible for providing the ambulance and escort team required for patient's transfer.

5.6.13.7 In case that patient transfer cannot be arranged within an acceptable timeframe for any reason, then the patient has to be admitted and transferred later when the transport is ready.

5.7 Referral to and from community health care services in PHC

5.7.1 Once it is decided that a patient does not require health care at a health facility but needs to be followed up in the community/home setting, the treating doctor can then refer the patient to the community health care services team in PHC for follow up.

5.7.2 Before referral, the doctor has to assess the patient against the criteria of admission to community health care services (refer to Primary Health Care Policies & Procedures – 2019). If these criteria are met and the patient or caregiver has no objection for such referral, then the doctor will ask the patient or patient's attendant to sign a consent. After that, the following procedures will be carried out at the referring institution:

5.7.2.1 The treating doctor will create an internal referral to the discharge planner or the concerned nurse in-charge informing him/her of the plan to refer the patient to the community health care services. The referral will contain the "admission criteria checklist" which was filled out by the doctor.

5.7.2.2 The discharge planner/nurse in-charge will review the checklist and confirm that the patient meets the admission criteria. The nurse will also identify and document any special needs or supporting equipment the patient will need at the home setting.

5.7.2.3 Once the referral is approved by the discharge planner/nurse in-charge, the doctor will receive a notification of referral approval.

5.7.2.4 The doctor will prepare and send a referral letter to the community health care services. The referral letter has to include all details of patient's condition, treatment, and future care plan, and it has to be attached with the signed consent form and the admission criteria checklist.

5.7.2.5 The discharge planner/nurse in-charge will receive a notification of the referral and will be able to communicate with the community health care services team to make the necessary arrangements, if any.

5.7.2.6 For more details of referral proceedings to community health care services, refer to "Primary Health Care Policies and Procedures – 2019".

5.7.3 At the community health services, the concerned staff will evaluate the referral and accept or reject it in a way similar to acceptance and rejection of other referrals (see section 5.4).

5.7.4 If the patient is accepted, the community nurse will open a file for the patient and book for his/her an appointment for home visit. The patient will receive SMS notification of the booked appointment and the date of home visit. The community nurse can also communicate with the patient or caregiver by phone to make the necessary arrangements for the home visit.

5.7.5 All information and findings relevant to patient home visit have to be documented in the community health services platform in the electronic system and it should be accessible to all relevant health institutions and providers.

5.7.6 If patient referral is rejected, the referring doctor has to check the reason for rejection and work on it, if possible.

5.7.7 For a rejected patient, it is the responsibility of the referring doctor to ensure continuity of patient's care either by:

- booking a new appointment for the patient (if not already booked),
- referring the patient to another health institution, or
- discussing the case with the community health services team to re-consider accepting the patient.

5.7.8 All other procedures of patient referral addressed in this document e.g. medications provision, appointment system, etc. are applicable to patients referred to community health care services.

5.7.9 If a patient is already in the community health care services program and found by the community nurse to be in need for doctor assessment, the nurse has to discuss the case with a PHC doctor in the catchment area the patient belongs to. The PHC doctor will then decide whether to manage the patient at the PHC institution or to refer him/her directly to another health facility that provide the required service.

5.7.10 If the patient will be referred to another health facility, the same referral procedures described in this document should be followed.

5.8 Referral for treatment abroad

5.8.1 Sending the patient abroad:

5.8.1.1 A doctor can recommend referring a patient abroad for treatment or investigation. This can be done through sending a recommendation to the "treatment abroad subcommittee" at the regional level. The sub-committee will then study the case and approve or disapprove the recommendation.

5.8.1.2 If the recommendation is approved, the sub-committee will inform the doctor who recommended the referral to prepare a full report about the case and to fill out the form of "Recommendation for Treatment Overseas". These documents will then be attached along with a compact disc (CD) containing all laboratory and radiology investigations and will be sent to the central committee.

5.8.1.3 If the central committee approves referring the patient abroad, the department of treatment abroad at MoH will then be responsible for communicating with the different bodies (locally and overseas) to make the necessary arrangements for patient referral.

5.8.1.4 The referring hospital will be responsible for providing the ambulance and escort team required for patient transfer.

5.8.1.5 More details on the regulations of referring patients abroad are available in the document "Regulations of treatment abroad and in private health facilities – Ministerial Qarar 84/2020".

5.8.2 Receiving the patient from abroad:

5.8.2.1 The department of treatment abroad is responsible for making the necessary arrangements for receiving patients who are referred back from abroad and assigning the hospital that will receive the patient. Hospital

selection will depend on the required medical service, the initial referring hospital, and the governorate the patient belongs to.

5.8.2.2 The department of treatment abroad will communicate with the focal point staff at the assigned hospital in order to make the necessary arrangements inside the hospital for receiving the patient.

5.8.2.3 The department of treatment abroad will also liaise, as much as possible, with the Health Attaché Office in the country where the patients will be sent from to ensure that the patient health status corresponds to what is mentioned in the patient's medical report.

5.8.2.4 The medical form specified for use in cases of receiving patients from abroad will be filled out and sent to the hospital assigned to receive the patient. This is important to keep the receiving hospital informed of patient condition and the required equipment and escort team for patient transfer.

5.8.2.5 In general, patients referred back from abroad should be received by the regional hospital to where the patient belongs, and the hospital shall be responsible for providing the ambulance, escort team, and all equipment necessary for patient's back transfer.

5.8.2.6 In case a patient belongs to a regional hospital that does not have the required service, the patient should be received by a hospital where the service is available, and that hospital will be responsible for providing the ambulance and escort team. When the treatment is over, the patient can then be referred back to his/her catchment area hospital as per the usual back referral procedures.

5.8.2.7 For patients who are sent for treatment abroad by non-MoH governmental health institutions that don’t have admission services (e.g. Diwan Medical Services) and the patient will require inpatient services upon arrival, the patient should be transferred back to the regional hospital of the health region the patient belongs to if the required service is available there, otherwise to the tertiary hospital that provides the required service. The referring non-MoH governmental health institution will be responsible for providing the ambulance and escort team.

5.8.2.8 In case a patient is intended for back transfer to a regional hospital outside Muscat Governorate and found in the airport to be unstable or require

immediate evaluation or intervention, the patient should be transferred to the emergency department of the tertiary hospital that addresses the patient's most urgent problem. In such situation, the escort team should remain with the patient and assist in patient management until the urgent event is resolved and the patient is stable to be transferred back to the regional hospital or to be admitted in the tertiary hospital.

5.8.2.9 In case a received patient is found in the airport to be in-need for additional equipment, the escort team should transfer the patient to one of the tertiary hospitals that can provide that equipment but after making the necessary arrangements through the administrations of the two hospitals. Once the equipment is provided and no further services are required, the patient can then be transferred to the assigned hospital which should return back the borrowed equipment as soon as possible.

5.8.2.10 Patients received from abroad and transferred back to a regional hospital should be received in the emergency department for evaluation by the concerned specialty. If the result of patient's evaluation shows that the patient does not require inpatient services then the patient can be discharged home and followed up in the OPD or in a primary health care facility according to the clinical judgment of the attending doctor.

5.8.2.11 Procedures of escorting patient abroad and receiving patient from abroad are explained in details in "Policy and Procedures of Patient Transfer – 2021".

5.9 Back referral

5.9.1 Generally, referred cases should be referred back to the initial referring facility once the reason for referral is resolved. However, in some cases and based on clinical grounds the referred doctor may decide to continue patient's management at the same institution or to back-refer the patient to another healthcare facility.

5.9.2 In case of back-referring the patient to another healthcare institution, the initial referring institution should be informed through referral feedback.

5.9.3 If a tertiary hospital arranged a bed in another hospital for a referred patient (whether in MoH or non-MoH hospital), the patient should be referred back to the initial referring hospital and not the tertiary hospital, provided that the required service is available in the back referred hospital.

5.9.4 For patients who are referred to MoH health facilities from non-MoH governmental healthcare institutions, the MoH health facilities can choose whether to back-refer the patient to the non-MoH governmental hospital/clinic or to another MoH institution. The same applies to non-MoH governmental healthcare institution when receiving referrals from MoH health facilities; they can choose whether to follow-up the patient or to refer him/her back to the respective regional hospital, local hospital, polyclinic or health centre based on patient's condition and service availability.

5.9.5 If a back-referred doctor decided later to refer again the back-referred patient to the same back-referring institution for any reason (e.g. patient's condition deterioration), then this should be considered as a new referral not a back referral.

5.9.6 Back-referral proceedings for inpatients:

5.9.6.1 On deciding to back-refer a patient, the back-referring doctor should prepare a referral letter and forward it to the back-referred institution.

5.9.6.2 The back-referring doctor has to contact the back-referred specialty and confirm bed availability before initiating patient transfer.

5.9.6.3 On confirmation of bed availability, the patient should be transferred back by ambulance and with appropriate escort team as described in section 5.11.

5.9.7 Back-referral proceedings for outpatients:

5.9.7.1 On deciding to back-refer an outpatient, the back-referring doctor should prepare a referral letter.

5.9.7.2 If the back-referred institution is connected electronically with the back-referring institution, the back-referral letter has to be sent electronically, otherwise to be handed to the patient to deliver it to the medical records department (MRD) of the back-referred facility. The MRD staff will then hand over the back-referral letter to the concerned speciality which will review it and proceed further as follow:

- If follow-up is required, an appointment will be booked for the patient.
- If medications are required, a copy of the back-referral letter will be sent to the pharmacy (if not already sent electronically by the back referring institution) to ensure medications' availability at the time of follow-up visit.

5.9.7.3 All other proceedings should remain the same as for routine referrals.

5.10 Referral medications (appendix 5)

5.10.1 Prescription referral:

5.10.1.1 For patients who have to continue their follow up at a health institution far from their place of residence, it is preferred that the patient's prescription is referred to a nearby health facility (if long term medications are prescribed) to make it easier for patients to collect their medications.

5.10.1.2 In such cases, the referring institution will be responsible for supplying the referred facility with the medication on regular basis.

5.10.1.3 The pharmacies in the referring and referred institutions will receive a notification of the referred prescription in order to make the necessary arrangements to supply and dispense the medications.

5.10.1.4 Any changes in the prescription during the follow up visits will require a new prescription's referral.

5.10.2 Patient referral:

5.10.2.1 The referring/back-referring facility has to clarify the referral duration period provided, that does not exceed one year maximum.

5.10.2.2 If the patient will be referred/back-referred to another health facility, then the patient's prescription is automatically referred/referred-back, provided that the referral/back-referral is accepted and the patient has to continue on medications beyond 3 months. Further proceedings are as follow:

5.10.2.3 For approved medications:

5.10.2.3.1 The referring/back-referring health facility has to provide the patient with medications for three months (can be dispensed on monthly bases). Prescription referral can be implemented in the initial months for patients who live in distant places as described above.

5.10.2.3.2 On receiving the referral/back-referral letter, the referred/back-referred facility will inform the Directorate General of Medical Supplies (DGMS) through the hospital's pharmacy about the referral and required medications.

5.10.2.3.3 The DGMS will then prepare and send the medications to the referred facility to be dispensed to the patient on monthly bases.

5.10.2.4 For non-approved medications:

5.10.2.4.1 The referring/back-referring facility has to provide the patient with medications for 3 months (can be dispensed on monthly bases), and to continue supplying the referred/back-referred facility with these medications on regular bases.

5.10.2.4.2 The referred/back-referred facility will receive the medications from the referring/back-referring facility and dispense them to the patient on monthly bases.

5.10.2.4.3 The pharmacy at the referred/back-referred facility has to receive a notification of the referred medications, and also it has to be notified if one of the non-approved medications is stopped.

5.11 Patient transfer

5.11.1 The details of patient transfer are elaborated in "Policy and Procedures of Patient Transfer – 2021". This section includes the main points related to patient referral.

5.11.2 The most senior doctor attending the patient should decide on the need for and the urgency of the transfer. The doctor should also communicate with the referred institution and get an acceptance for patient transfer.

5.11.3 Once the transfer is agreed and accepted electronically (except for emergency referrals), an automated notification will be sent to the bed managers/supervisors in both hospitals informing them of the potential transfer. The bed managers will then be able to communicate with each other electronically through the E-referral platform to make the required arrangements for patient transfer (e.g. time of transfer, infection control measures required, etc.).

5.11.4 If a patient is accepted to be transferred to a certain hospital and then the patient condition changed, the referring doctor have to inform the referred doctor about the new changes as the referred doctor may opt to change the treatment plan or transfer decision.

5.11.5 It is the responsibility of the referring doctor to ensure that the patient is prepared for transfer, all necessary equipment for safe transfer are available, and all

relevant documents are complete and sent electronically or handed to the escort team.

5.11.6 The referring doctor should perform risk-benefit analysis to ensure patient safety during the transfer process. If the transferred patient is unstable or if there is possibility of patient's condition deterioration during transfer, a doctor must accompany the patient to the referred institution.

5.11.7 Before any transfer, the patient should be stabilized as much as possible, and all necessary measures to ensure patient safety and stability during transfer should be carried out (e.g. securing the airways, ensuring patent venous access, etc.).

5.11.8 Members of the escort team should have appropriate competencies and experience, preferably formal training in cardiopulmonary resuscitation (CPR) and safe transfer of patients.

5.11.9 The main escort staff should be aware of the patient's condition and possible risks (e.g. risk of contracting infection from the patient). They should also review the transfer form and be clear about all instructions recorded in it.

5.11.10 Non-emergency transfers should be carried out preferably during the daylight hours. Night transfer should be dictated according to extreme clinical criteria and approved by the most senior doctor.

5.11.11 At all times during patient transfer, the ambulance driver has to exercise defensive driving precautions and avoid over speed. The roles of ambulance driver in patient transfer are specified in "Policy and Procedures of Patient Transfer – 2021".

5.11.12 The transfer staff should monitor the patient condition throughout the transfer journey and ensure that the vital signs are stable and the patient is as comfortable as possible. Any changes in patient's condition or vital signs should be documented in the escort form.

5.11.13 The referred institution/department should ensure that necessary arrangements are made to receive the transferred patient without any delay.

5.11.14 The referred institutions should prioritize attending escorted patients in order to speed up the return of the escort team to its workstation. Escorted patients should always take precedence over less urgent cases.

5.11.15 Under no circumstances the escort team shall be detained for more than one hour to handover the patient. If such detention happened, the escort staff should report the incident to their hospital director through the regular reporting channels.

5.11.16 The escort team should hand over the patient to the receiving staff and report any events or changes in the patient's condition happened during the transfer trip.

5.11.17 The receiving doctor/nurse should take over the patient, ensure patient stability and inform the concerned doctor if the referred doctor is other than the receiving one.

5.11.18 Once the handover procedure is completed, the patient becomes under the referred speciality care and the escort team can return back to its workstation.

5.11.19 If the patient is escorted only for a consultation or specific procedure, the escort staff should accompany the patient to the consultation or investigation room with help from the referred institution staff, if necessary.

5.11.20 If prior arrangements were made between the referring and referred institutions to back transfer another patient to the referring hospital during the return trip, the escort team should be informed earlier at the referring institution regarding that back transfer in order to take all necessary precautions for two transfers. If the ambulance and escort team require any additional equipment for the back transfer, then the back-referring hospital has to provide them.

5.11.21 Hospital entry points for transferred cases:

5.11.21.1 Neonatal cases: all transferred neonates irrespective of the clinical condition of the neonate should be wheeled directly to the special care baby unit (SCBU) without the need to stop over in the emergency department (ED).

5.11.21.2 Paediatric cases: transferred paediatric cases should be directed to the paediatric emergency department if available, otherwise to the general ED. Further proceedings will be determined by the clinical condition of the child as detailed below.

5.11.21.3 Obstetric cases: pregnant women should be directed to the delivery suite if they are transferred for obstetric conditions, and to the adult ED if they are transferred for non-obstetric conditions. Further proceedings will be determined by the clinical condition of the patient as described in details below.

5.11.21.4 Other transfers: other escorted cases regardless of the referral category (emergency, urgent, routine) should be received in the ED and dealt with according to the clinical condition of the patient as detailed below.

5.11.22 Further proceedings for transferred cases received in the ED:

5.11.22.1 Stable patients:

5.11.22.1.1 Stable patients should be directed to the concerned department/ward by the escort team and with a help from an ED staff, if needed.

5.11.22.1.2 The patient and referral documents should be handed over to the concerned ward/department nurse who shall endorse patient reception and document it in the escort form.

5.11.22.2 Unstable patients:

5.11.22.2.1 The ED doctor and based on the degree of patient instability should decide whether to transfer the patient to the concerned ward or to request the concerned doctor to attend to the emergency department.

5.11.22.2.2 If the ED doctor decides to transfer the patient to the concerned department, then a doctor from the ED or the referred department (depends on the internal regulation of the hospital) should accompany the patient to the ultimate ward. Handing-over/taking-over procedures should remain the same as for stable patients.

5.11.22.2.3 If the ED doctor decides to call the concerned doctor to attend to the ED, the ED staff should take-over the case and assume full responsibility for further patient care. The escort team should wait until arrival of the referred doctor who may need to know more information about the patient, provided that the total waiting time does not exceed the specified timeframe. The escort team can then be released to return to its workstation.

5.11.22.2.4 In both situations, the escort team is not responsible for accompanying the patient for any investigation or procedure not planned before transfer.

5.11.22.3 Critical cases:

5.11.22.3.1 The ED staff should take-over the case immediately and initiate all necessary treatment as for other similar emergencies.

5.11.22.3.2 The escort team should wait until arrival of the referred doctor who will be called to attend immediately to the emergency department.

5.11.22.3.3 If the patient needs to be wheeled to any critical area, the escort team should assist in shifting the patient.

5.12 Transfer of patient with infectious disease

5.12.1 In general, infection control procedures should always be implemented regardless of the infectious status of the patient.

5.12.2 Specific isolation precautions should be implemented for specific infections e.g. wearing aprons during the transfer of patients with contact-transmitted infections, using fit-tested respirator particulate mask (N95 or higher) when transferring patients with airborne-transmitted infections, putting surgical mask for droplet-transmitted infections, etc.

5.12.3 For patients with infectious diseases, transfer to other hospitals should be limited to urgent conditions only and the number of staff involved in patient transfer should be kept to a minimum, provided that the transfer process will not be affected by the low number of staff.

5.12.4 Healthcare workers who are not immune to the infection incurred by the transferred patient (if vaccine-preventable infection) should not participate in the transfer process, whenever possible.

5.12.5 All staff involved in patient transfer must be informed of the risk of contracting the infection and they must implement all protective procedures, general and infection-specific precautions.

5.12.6 The patient should always be involved in the prevention of infection transmission by instructing him/her to maintain the protective measures during the transfer process e.g. wearing a protective apparel, putting a mask, etc.

5.12.7 Staff at the referred hospital should be notified early of the infectious status of the transferred patient and the expected time of arrival so they will have enough time to implement the required infection control procedures.

5.12.8 On arrival, the receiving staff should keep all patient infection control equipment in place and consider implementing additional protective equipment or isolation procedures if necessary.

5.12.9 If the patient is transferred for an outpatient procedure or consultation, the procedure should be expedited to minimize patient waiting, and once the procedure is over all equipment and surfaces should be cleaned immediately before the next patient.

5.12.10 When the procedure or consultation is over, return of the infectious patient to the original referring institution should be done as soon as possible and with implementation of the same infection control procedures carried out during the referral process.

5.12.11 If a member of the transfer team gets accidentally exposed to a potentially infectious material from the patient (e.g. body fluids, excretions, tissues), emergency procedures should be carried out immediately and medical advice from infectious diseases specialist should be sought.

5.12.12 Infection prevention and control teams in hospitals should monitor compliance with infection control procedures when transferring patients and they should provide advice as required.

5.12.13 For more detailed information about transfer of patients with infectious diseases, refer to "Policy and Procedures of Patient Transfer – 2021".

5.13 Transfer of burn cases

5.13.1 In general, burn patients should be transferred to a specialized burn unit for the definitive management of the burn wounds if they fulfil the referral criteria.

5.13.2 Before transfer to the burn unit, the patient must be stabilized. No patient should be transferred to the burn unit before treating the burn shock for a period of 48 hours.

5.13.3 If a burn unit is available in the same hospital, then the patient has to be shifted to that unit after stabilization, otherwise to the nearest burn unit based on bed and expertise availability.

5.13.4 Regional burn units may communicate with the National Burn Unit (NBU) in Khoula hospital for guidance and advice regarding difficult or serious cases which can also be transferred to the NBU after mutual agreement.

5.13.5 Before any transfer to the NBU, the referring doctor should first discuss the case with the referred doctor and get approval regarding patient transfer. Once the

referral is approved, the patient can then be referred to the NBU implementing the same transfer procedures described above.

5.13.6 Along with the referral and escort documents, the following documents should be attached: screening reports for hepatitis, HIV, MRSA, and MDR organisms, burn shock treatment chart, fluid intake-output chart, and chart of estimating burn wound severity.

5.13.7 For more details on referral and management of burn patients, refer to the "National Guideline for the Management of Burns in OMAN – 2019".

5.14 Referral feedback

5.14.1 Referred doctors should always give feedback about all cases referred to them (inpatient and outpatient), even if the referred doctor decided to continue patient's management at the same institution.

5.14.2 The referral feedback should contain enough information about the clinical findings, diagnosis, investigations, and the treatment given, as well as the future management plan.

5.14.3 The OPD note and discharge summary are not referral feedback.

5.14.4 For health institutions which are connected electronically, the referral feedback will be sent automatically to the referring institution once the patient's discharge is confirmed for inpatients, and after some time of saving the OPD note for outpatients. The referral feedback will reach the concerned speciality in the referring facility with a notification.

5.14.5 For health institutions which are not connected electronically, the feedback letter should be handed to the patient if he/she will be discharge home or referred to another hospital.

5.14.6 If the patient will be back referred/transferred to another hospital then the following should be considered:

5.14.6.1 If the patient is referred/transferred back to the initial referring institution, then the referral feedback is unnecessary because the back-referral letter will substitute the referral feedback.

5.14.6.2 If the patient is referred/transferred back to a facility other than the initial referring institution, then the initial referring institution will receive referral feedback and the back-referred institution will receive a back-referral letter.

5.15 Appointment procedures

5.15.1 All urgent and routine referrals have to be effected through prior appointments. Such appointments are not required for emergency referrals.

5.15.2 All appointment requests should be reviewed by a doctor from the referred specialty and dealt with as described in section 5.4.

5.15.3 If a received referral/appointment request is accepted, the doctor will choose whether to give a management advice or an appointment. If an appointment will be given, the available options will be: in-person visit or virtual clinic.

5.15.4 The response time for urgent referrals should not exceed 24 hours, and these referrals should be given appointments within 72 hours of receiving the appointment request.

5.15.5 The response time for routine referrals should not exceed 3 working days, and these referrals should be booked for next available vacant slot.

5.15.6 If an early appointment is requested for a routine case, the patient should also be put in the "early appointment waiting list" to get an early appointment against any cancellation. Such appointments will be listed according to precedence of requests.

5.15.7 The referred facilities should always adhere to the appointment timeframes specified for the different referral categories.

5.15.8 Requesting and booking appointments have to be done through the electronic system, wherever possible.

5.15.9 For each appointment, the patient will receive SMS notification of the booked appointment and another SMS reminder few days before the appointment day. The patient has to confirm appointment attendance through an interactive message. For unconfirmed appointments, the MRD staff may call the patient to ascertain attendance or appointment cancellation. Cancelled appointments can be used for patients in the early appointment waiting list or other routine referrals. This can also help in reducing the number of defaulters.

5.16 Referral quality and KPIs

5.16.1 The reason for referral has to be indicated clearly in the referral letter, and it will fall under one of the following categories:

1. Expert Opinion/Management (e.g. for second opinion, the needed speciality is not available in the current facility, etc.)
2. Resource Unavailability (e.g. lack of the equipment, investigation, treatment)

3. Continuation of Care (e.g. follow up, nursing care, performing a monitoring test)
4. Pre-anaesthesia Check-up
5. Missed Appointment
6. For Procedure
7. For Local Visit
8. Others “specify” (for temporary or exceptional situations e.g. specialist is on leave, CT-scan machine not working, no admission bed, etc.)

5.16.2 Inappropriate referrals should be dealt with at the administrative level and should never be discussed with the patient or patient's attendant. Disrespectful remarks on the referral are both unacceptable and unethical and any confirmed violation will result in disciplinary actions.

5.16.3 The Directorate General of Quality Assurance Centre (DGQAC) should implement a comprehensive monitoring system at the central and institutional levels to monitor compliance to the referral procedures.

5.16.4 The key performance indicators (KPIs) for the referral process are listed in appendix 6. Health institutions can develop and implement more performance indicators to monitor their incoming and outgoing referrals.

5.16.5 The electronic system will generate monthly reports of any deviation from the defined standards for the referral KPIs and will send them to the quality and patient safety in-charge staff as a part of the incident reporting & learning system (IRLS) in order to take the necessary actions.

6. Responsibilities

6.1 It is the responsibility of all concerned staff to ensure that they have read and understood this document, and to carry out their referrals according to these procedures.

6.2 It is the responsibility of hospital directors, medical officers' in-charge, and heads of relevant departments/sections/specialities to ensure implementation and compliance with these referral procedures and to clarify any incomprehensible points to their staff.

6.3 It is the responsibility of the different specialties to develop standard operating procedures (SOPs) that state the referral criteria for the various clinical conditions and to specify the referral category for these conditions.

7. Document history and version control

Document History and Version Control			
Version	**Description of Amendment**	**Author**	**Review Date**
01	Initial release – 1999	Directorate General of Health Affairs	
02	Second edition – 2004	Directorate General of Health Affairs	
03	Third edition – 2021	Directorate General of Specialized Medical Care	November 2024
04			
05			

Written by	**Reviewed by**	**Approved by**
Dr. Rashid Al Shakaili	Dr. Adil Al Ansari	Dr. Kadhim Sulaiman

8. Related Documents

8.1 Policy & Procedure of Incident Reporting & Learning System (MoH/DGQAC/P&P/002/Vers.01)

9. References

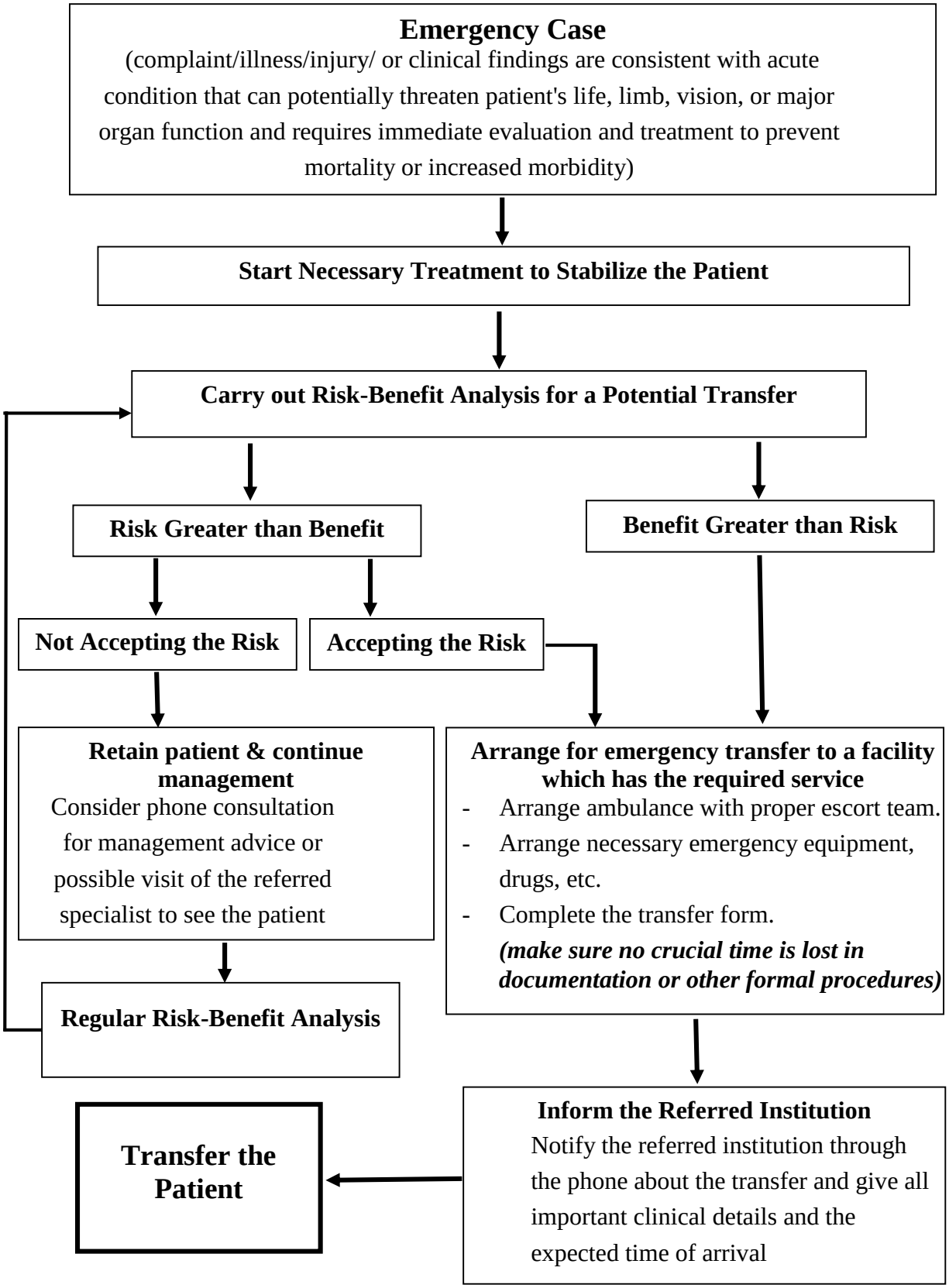
Title of book/ journal/ articles/ Website	Author	Year of publication	Page
Patient Referral Guidelines Manual, Second Edition	Directorate General of Health Affairs, MoH	2004	
Policy and Procedures of Patient Transfer	Patient Transfer & Transport Taskforce	2021	
Annual Health Report	Department of Health Information & Statistics – Directorate General of Planning & Studies	2018	
National Guideline for the Management of Burns in Oman	Directorate General of Khoula Hospital	2019	

Appendix 1:

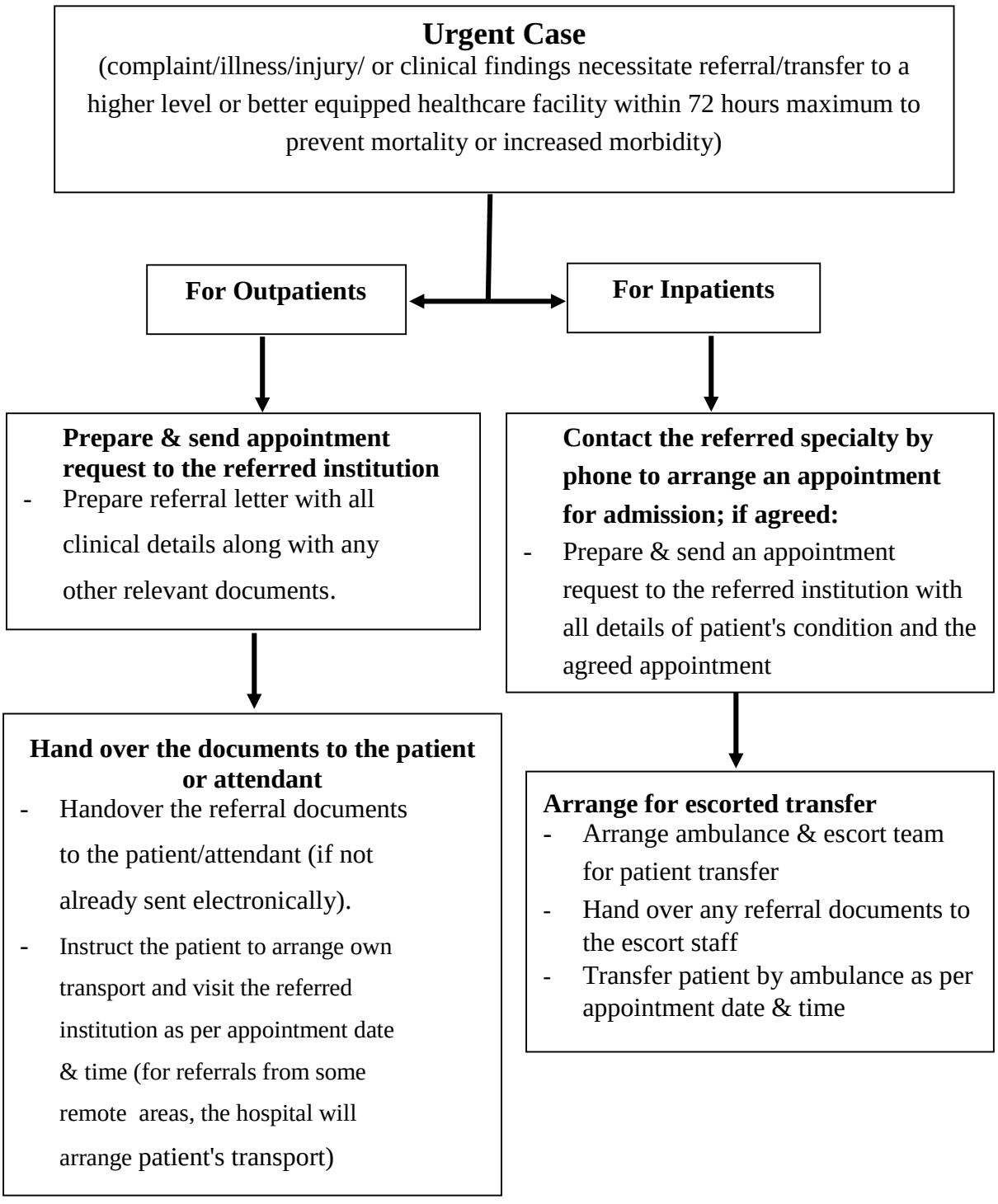
1. **Diseases and surgical procedures excluded from the list of free services provided to government-employed expatriates:**
   - Organ transplant
   - Open heart surgery
   - Cancers
   - Hepatitis – all types
   - Infertility
   - Inherited and cancerous blood disorders
   - Reconstructive surgery
   - Renal dialysis
   - Prosthetics (bony and non-bony)
   - Addiction
   - Heart diseases
   - Lung fibrosis
   - Multiple sclerosis (MS)
   - Acne
   - Attention deficit hyperactivity disorder (ADHD)
   - Schizophrenia
   - Alzheimer
   - Metabolic diseases

2. **Medications excluded from the list of free services provided to government-employed expatriates:**
   - Biological products used of rheumatoid arthritis and psoriasis (e.g. Inj. Tocilizumab, Inj. Adalimumab, Inj. Etanercept, Inj. Ustekinumab, Inj. Infliximab)
   - Biological products used for asthma (e.g. Inj. Omalizumab)
   - Biological products used for retinal diseases (e.g. Inj. Bevacizumab, Inj. Ranibizumab)
   - Insulin analogues/GLP-1 analogues/DPP-4 inhibitors used for diabetes (e.g. Inj. Insulin Glargine, Lispro, Glulisine Aspart, Inj. Liraglutide, Sitagliptin tab, tab Lingliptin)
   - Biological products used for renal failure (e.g. Inj. Erythropoietin, Inj. Darbepoetin, Inj. Methoxy Epoetin)
   - Botulinum toxin (drug used for muscle spasticity and excessive sweating)

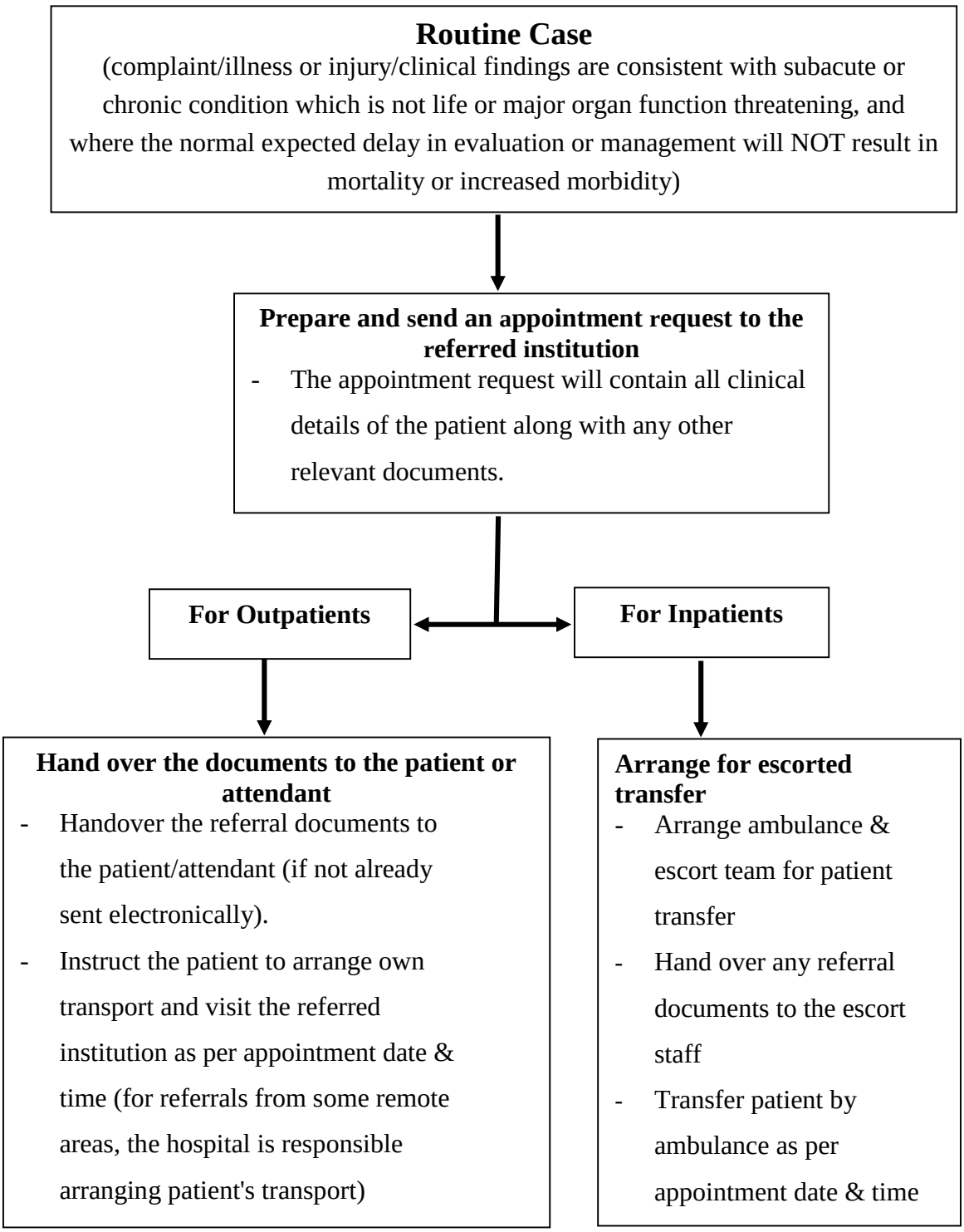
Appendix 2: Emergency Referrals



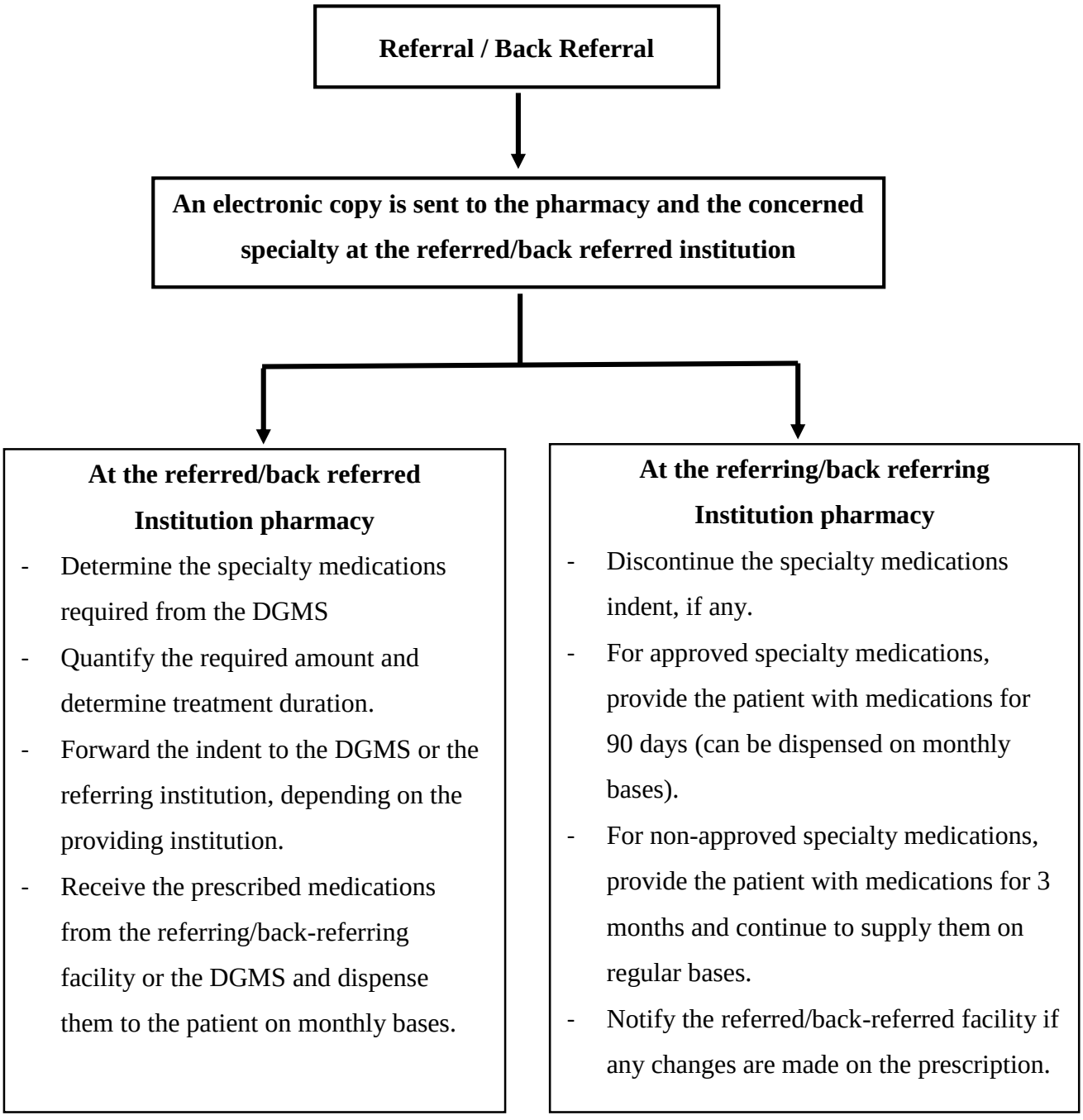
Appendix 3: Urgent Referrals



Appendix 4: Routine Referrals



Appendix 5: Referral Medications



Appendix 6: Referral Process KPIs

The evaluated component of the referral process	Rationale	KPI calculation
1. Referral quality	• To identify the percentage of rejected and inappropriate referrals • To assess the reasons for rejection and take the necessary actions for improvement	1. Total number of rejected referrals / Total number of referrals x 100
		2. Number of misdirected referrals / Total number of referrals x 100
		3. Number of unjustified referrals / Total number of referrals x 100
		4. Number of referrals with insufficient clinical information / Total number of referrals x 100
2. Response to appointment requests	• To assess whether responding and giving appointments to referrals is within the specified timeframe or not • To identify the reasons for any deviation and take the necessary actions.	1. Number of urgent appointment requests replied after the stipulated time (1 day) / Total number of urgent appointment requests x 100
		2. Number of routine appointment requests replied after the stipulated time (3 working days) / Total number of routine appointment requests x 100
		3. Number of emergency referrals failed to be seen within 24 hours / Total number of emergency referrals x 100
		4. Number of urgent referrals given appointments after the specified timeframe (3 days) / Total number of accepted urgent referrals x 100
3. Referral feedback	• To identify the percentage of referrals which received feedback and take the necessary actions for any deviation.	1. Number of feedback received for referred outpatients (including defaulters) / Total number of referred cases for outpatient care x 100
		2. Number of feedback received for referred inpatients / Total number of referred cases for inpatient care x 100