A MINIMUM DATA SET FOR THE OUTPATIENT CLINIC RECONCILIATION FORM

Guidance

009

FUNCTION OF THE CLINIC RECONCILIATION FORM

To enable (i) accurate recording of the major components of the patient's clinic attendance status and (ii) support appropriate follow-up actions that result from that consultation.

The clinic reconciliation form should be completed for each patient attendance and filed as per healthcare records management policy. All completed forms should be made available to staff evaluating performance, where required.

DATA ITEMS

Data items for inclusion in the clinic reconciliation form are set out in Table 1:

Table 1: Minimum Data for Clinic Reconciliation Form

1. Patient ID/name, waiting list code, guardian (where applicable), GMS number, and episode number

2. Patient/guardian Address, lines 1,2, and 3

3. Patient date of birth

4. Patient/guardian phone numbers (landline and mobile)

5. Patient SOR/GP, with address and telephone number

6. Clinic PAS code

7. Specialty, sub-specialty, and specialty code

8. Clinician name and code

9. Clinic date

10. Demographic and SOR/GP details confirmed by patient

11. Patient attended, patient failed to attend, patient cancelled on the day of clinic

12. Consultation outcome:

    o Discharge to GP/SOR; Review appointment; Diagnostic investigation; Review following diagnostic; Recall for outpatient treatment; add to inpatient waiting list; add to day case waiting list; Refer to another specialty/service; Refer to another hospital/service-provider

13. Failure to attend/cancellation outcome:

    o Issue new appointment; Remove from wait list/discharge; Contact GP/SOR re urgent (including cancer/red-flag) patient's failure to attend/cancellation; Contact urgent patient directly to arrange new appointment

14. Review arrangements:

    o Within six (6) weeks; Review waiting list; Planned consultation list

15. Time of patient registration (24 hour clock); Time of first clinical contact; Time of primary clinical consultation; Time of consultation end