A MINIMUM DATA SET FOR SOURCE OF REFERRAL REPORT/DISCHARGING PATIENTS FROM OUTPATIENT SERVICES

January 2014

Outpatient Services Performance Improvement Programme

Guidance

010

Data Item		Definition
Patient Details		
1	Health identifier	A number or code assigned to an individual to uniquely identify the individual within an organisation
2	Forename	A patient's first name or given name (s) as per their birth certificate
3	Surname	The second part of a patient's name which denotes their family or marital name
4	Address	The location to be used to contact or correspond with the patient. This would normally be the patient's usual home address
5	Date of Birth	Date of birth indicating the day, month, and year
6	Gender	Gender identity is a person's sense of identification with either the male or female sex, as manifested in appearance, behaviour and other aspects of a person's life
7	Guardian Name and Address (where applicable)	Forename, surname and address of the guardian where, for example, the patient is a child
8	Patient's Pharmacy	Address of the pharmacy routinely used by the patient and/or where he/she is registered under the drugs payment scheme
9	Medical Card Number	Patient's GMS number, where applicable
Health Care Professional Information		
10	Forename	First name or given name of primary care healthcare professional
11	Surname	The second part of a primary care healthcare professional's name which denotes their family or marital name
12	Address	The particulars of the place used to correspond with the patient's primary healthcare professional
Referral & Episode Details		
13	Hospital/service-provider site	The site the patient attended/was discharged from
14	Date of referral	The date of the referral that initiated the episode of care
15	Specialty/discipline	Specialty or discipline the patient attended/was discharged from
16	Source of referral	This describes who made the decision to refer the patient
17	Attendance number	Total number of attendances by the patient within this episode of care (first, subsequent and current/final consultation)
18	Date of most recent attendance (where not discharging)	Date of most recent attendance and to which this report relates
19	Date of final attendance	Date of final consultation where decision to discharge was made
20	Where not discharging patient, reason for continued care/requirement to review	Reason the patient cannot be discharged
21	Name, job title of principal healthcare professional seen at most recent/final consultation	The name and job title of the healthcare professional seen during the substantive component of the consultation
Pertinent clinical and care plan information		
22	Diagnoses	The diagnoses established after study to be chiefly responsible for occasioning an episode of care and conditions or complaints either coexisting with the principal diagnosis or arising during the episode of patient care
23	Hospital/service-provider course	Include a description on the course of the patient's illness during the episode of care
24	Relevant investigations and results	Relevant assessments, investigations and/or observations, operations, procedures undertaken for diagnostic purposes on the patient during the episode of care
25	Relevant treatments and changes made in treatments	The relevant treatments which the patient received during the episode of care
26	Clinical alerts	Information about a specific patient required for the management of a patient in order to minimise risk to the patient concerned, healthcare staff, other patients and the organisation. It is a warning of a medical condition or risk factor that requires consideration before treatment is initiated
27	Allergies	Include information about all allergies known
28	Adverse events	Include information about all hypersensitivities and/or adverse events known about the patient that may put the patient at risk
29	Medication to be continued	The medications the patient is intended to take after the consultation/after discharge

30	Medications stopped or withheld	A pertinent history of changes to the medication that the patient was taking prior to this most recent/final consultation
31	GP actions	Actions that are requested of the general practitioner
32	Social Care actions	Actions relating to the person's social care that have been requested to be undertaken
33	Information given to patient and carer	Information, both verbal, written or in any other form which has been provided to the patient, relatives or carer
34	Advice, recommendations and future plan	This should include any advice, recommendations or actions that were requested from other healthcare professionals and health promotion activities the patient was advised to undertake. For example, a smoking cessation programme
Who Completed Form & Sign Off		
35	Forename	A first name or given name of the person completing the discharge summary
36	Surname	The second part of a name (family or marital) of the person completing the discharge summary
37	Contact number	The usual contact number for the person completing the discharge summary
38	Job title	The job title of the person who completed the discharge summary
39	Professional body registration number	The professional registration number of the person completing the discharge summary
40	Signature	The signature of the person who created the discharge summary
41	Copies to	A list of people to whom copies of the discharge summary should be sent
42	Date of completion of report/discharge summary	The date the report/discharge summary was completed
43	Consultant/lead clinician sign off	If the person completing the discharge summary is part of a consultant-led team the consultant may countersign the report/discharge summary
44	Date of consultant/lead clinician sign off	The date the consultant countersigned the report/discharge summary
45	Document reference number	An alphanumeric identifier which uniquely identifies the discharge summary document and may be used to reference the discharge summary document