Government of **Western Australia**
Department of **Health**

Service Collaboration Toolkit

Memorandum of Understanding

Referral Feedback Templates

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Preface

The **Walk With Me Project:** Pathways to Alcohol and Other Drug (AOD) Early Intervention and Withdrawal Management (the Project) was commissioned in response to several key findings and recommendations in the *WA Methamphetamine Action Plan Taskforce Final Report (2018)*, in particular:

- The challenges people face with accessing drug and alcohol services when, where and how they are needed; and without help to do so – juxtaposed against the relative ease of access to substances: *"Take a walk with me" meth users have said to me. "I'll find you three shots in 15 minutes."*
- The need to improve access to alcohol and other drug services, including withdrawal management care, within WA Health and at the interface between WA Health and Community-based AOD service providers.
- The need to intervene early to reduce AOD-related harm and prevent entrenched use, promoting the use of screening tools and establishing targeted early intervention pathways.

The Project is a Health Service Provider (HSP) collaborative between the East Metropolitan Health Service (EMHS), North Metropolitan Health Service (NMHS), South Metropolitan Health Service (SMHS) and WA Country Health Services (WACHS). The Project also incorporates relevant areas/directorates within the WA Department of Health.

The Project reflects on how clinicians can better walk with our patients/service users on their journey with alcohol and other drugs, including screening and early intervention to prevent harm and reduce entrenched use, provision of AOD withdrawal management, and the partnerships and pathways at the interface between HSPs, primary care providers and Community-based AOD services, through a patient-centred approach that reflects individual patient's wishes and goals.

This toolkit…

This toolkit should be utilised alongside the *Alcohol and Other Drugs Partnerships and Pathways* clinical practice guideline, providing a framework and templates which can support establishing and enhancing new or current AOD partnerships at the interface between hospital and community service providers such as Community Alcohol and Drug services (CADS), NGO's and private service providers.

As outlined in the *Alcohol and Other Drugs Partnerships and Pathways* guideline, HSPs, General Practitioners and community based AOD service providers need to work together to establish and build effective partnerships that support the consumer's journey between service providers and towards their individual goals.

Throughout the Project's consultation with relevant stakeholders, the need to improve communication and feedback following patient referral was consistently highlighted at all levels. Whilst individual examples of excellent practice were identified, this is occurring on an infrequent basis rather than being consistent and routine practice guided by procedure and process.

The Methamphetamine Action Plan Taskforce also heard from consumers about the importance of co-ordination and collaboration:

"They identified the need for the different parts of the 'system' to work better together. They spoke of the need for more coordination and collaboration and to share information between each other. Many also recognised the need to better evaluate the results of what they do and to share the lessons learnt with other providers."

This toolkit (with templates included) is designed as a flexible guide, providing services with an outline to support local process development and enhance and review relationships at the hospital interface. Whilst this toolkit promotes consistency and standardisation of process, it recognises the need for site-specific flexibility, considering differing priorities, local context, variable resource capacities and existing pathways and templates. It is recognised that each HSP is at a different stage in applying AOD management practice and pathways. Therefore, implementing these tools should take into consideration:

- Existing partnerships, operational documents, initiatives and programs that support the principles of AOD withdrawal management, and how elements of the model can complement or add value to them.
- Sites with co-located / integrated Mental Health Teams and CADS that have established MOC and partnerships eg WACHS
- Current organisational and staffing culture and attitudes towards AOD use, and people who use alcohol and other drugs.
- Benefits of taking a phased approach to applying the model to practice.

Chapter 1: Developing Strong Local Partnerships

The *Alcohol and Other Drugs Partnerships and Pathways* guideline highlights how a partnership approach is fundamental to effective care coordination, improved communication and a patient centred flow of care. This patient-centred approach supports a shift away from fragmented and episodic care, and instead towards seamless, integrated and interagency service delivery [1].

A holistic, flexible and client-centred approach is required to recognise and manage the complexity of a client's care goals and ensure that the risk of relapse into harmful patterns of use is not further exacerbated by weaknesses in service delivery or organisational processes [2]. There is an additional need to support clients through sustained engagement with the broader health system as well as welfare and other sectors. It is therefore essential that organisations remain committed to collaborative practice and open communication [3].

To be successful, partnerships should have a clear purpose, add value and be subject to regular monitoring. The partnerships analysis tool provided by VicHealth [4] provides a good example of process and a checklist for assessing the strength and utility of a planned or established partnership.

When creating local partnerships, it is important to consider opportunities to include other sectors, promote effective inter-agency communication and ensure that all staff have the skills, knowledge and systems in place to simplify process and support effective partnerships [5]. General Practitioners (GPs) are essential partners in care coordination for people with complex and chronic health conditions including alcohol and drug issues. GPs are the primary point of access to the broader health system for the community [1]. It is recommended that service providers work closely with the patient's GP to ensure that consumers have access to coordinated and consistent care which meets their individual needs.

1.1 Sharing information and consumer consent

Sharing a consumer's personal (including health) information between partner service providers facilitates the principle of shared care and care that is responsive to the consumer's present needs and circumstances. This can be facilitated by establishing streamlined processes to seek and document informed consent from the consumer to share their information between partner service providers.

It is recognised that the incidence of trauma in this cohort is high and by using a trauma informed approach to engagement with consumers, including choice and collaboration in the sharing of information and referral feedback process is vital to ensuring that consumers and their families are central to treatment goals. Utilising a "no wrong door" practice ensures that all consumers receive appropriate treatment regardless of their point of entry to the service.

Where informed consent is provided, effective information sharing between partners can be facilitated by following a mutually agreed information collection and transfer process. This may also involve identifying key positions within each service provider that are responsible for the transfer and receipt of information. Communicating mutually agreed processes and associated roles and responsibilities to all staff involved is critical to managing expectations and maintaining good working relationships between partner service providers.

The **Privacy Act 1988 (Cth)** sets out privacy principles relating to the collection, use and disclosure of personal information. Each service provider is to uphold consumer confidentiality and privacy rights during the collection, use and disclosure of personal information. There are situations where information may be shared between agencies without the consumer's consent as part of the service provider's duty of care (e.g. safety of the consumer or the wider public).

Chapter 2: Memorandum of Understanding

Creating agreements between HSPs and their local area community managed organisations such as community alcohol and drug services, NGOs and private practice services, signals the willingness of both parties to build a partnership that focuses on the patient at the centre of their journey. It is recommended that a Memorandum of Understanding (MOU) is based on a shared vision and should include:

- roles and responsibilities of participating organisations
- principles, protocols, policies and functional working arrangements that facilitate effective communication and collaboration
- processes for information sharing between sites while maintaining confidentiality
- clear referral pathways and feedback loops including receipt of referral, engagement, and discharge with timeframes and minimum communication expectations
- an integrated, patient-centred approach to joint case management and responsibilities, including case conferencing between HSPs, CADS and local GPs
- support for comprehensive and flexible discharge planning that includes all appropriate agencies, GPs, consumers and their family and carers, and
- collaborative staff development and training initiatives such as staff placements.

An MOU is not a legally binding contract. It is a voluntary agreement that is intended to support agencies in working together efficiently. It does not create legally binding rights and obligations.

2.1 Key Inclusions

Background and Introduction:

- The context of your partnership.
- A list of participating agencies and key stakeholders.
- Principles and practices relevant to the partnership.
- Rationale for the MOU.
- Relevant policy context.
- Best practice guidelines and documents that underpin the approach.

Purpose:

- A brief description of the purpose of the MOU (what is included and how it will be applied).

Scope:

- Agreed inclusion and exclusion criteria.

Principles:

- Underpinning principles and aims of the working partnership.

Term:

- Timeframe for which the MOU will be applied.
- A schedule and strategy for review.

Descriptor of Services:

- The programs/services within each participating service, to which the MOU applies.

Working Relationship Between Services:

- Specific objectives or aims that participating services agree to take to support effective service coordination and improved patient care.
- Roles and responsibilities of each service.
- Relevant key contacts.

Key Processes:

- Referral pathways.
- Provision of Referral Feedback and communication of shared patient information.

Collaborative Staff Development Training and Initiatives:

- Outlines opportunities for cross sectoral training.

Confidentiality:

- Details provision of Privacy Act and documentation of patient consent for sharing of information between partner agencies.

Costs:

- Outlines any resources / service responsibility associated with the MOU.

Dispute Resolution and Clinical Incident Management:

- Agreed guidelines and procedures for management of critical incidents and process for conflict and conformity resolution.

An example Shared Vision document is provided in Appendix 1.

An example MOU template is provided in Appendix 2.

Principles of Practice

Effective engagement with patients/service users regarding their alcohol and other drug use requires:

- an empathic and unprejudiced approach
- seeing the patient as an individual with their own story, journey and needs
- assisting patients/service users to choose the management option(s) that best suit their needs and goals at that presentation
- respect for the patient and their choices with objective, open discussion
- consideration of unique issues for consumers with complex medical or psychiatric, cultural and language-diverse needs, pregnant women, young people and the elderly who may require a tailored and individualised approach within existing services
- post withdrawal care planning is a vital component of successful withdrawal management. A collaborative partnership includes the patient, their family / significant others (where appropriate) and community-based service providers engaged as mutual partners in treatment planning and all aspects of care.

Chapter 3: Referral Pathways

3.1 Definitions

Referral Definitions

Passive Referral: The patient is given the details of the service and make their own appointment. This method is best for patients/service users who are motivated, able to plan and can manage their own care. Rarely is it suitable for patients/service users with complex or co-occurring mental health and AOD issues [6].

Active Referral: A clinician makes a referral on behalf of the patient. Active referrals can be verbal (for example, a phone-based communication between agencies), fax, letter, secure email, or via an electronic referral system. The clinician provides the appropriate clinical information about the patient with a professional assessment of the patient's needs. This method of referral is recommended for patients/service users with complex needs or co-occurring mental health issues [5]. Assisted referrals are subject to consent and should be documented according to relevant legislation.

Active referral is preferred when:

- A patient is cognitively impaired (e.g. brain injury / intellectual disability / dementia) to a point where a successful self-referral is unlikely.
- Medical treatment is strongly indicated for saving life.
- The patient's mental state and social circumstances make it unlikely that they would follow through on a self-referral, for example:
    - experiencing grief or loss
    - personality characteristics
    - chaotic lifestyle
    - the patient's carer may not be sufficiently reliable or capable.
- To support the patient to move to the next point in the stages of change cycle, i.e. where the client would be unlikely to be sufficiently self-motivated to take the next step but may feel obligated or encouraged to do so by a written referral.
- It is desirable to place on record the actions taken to assist a client (e.g. duty of care).
- A client specifically requests support to make a referral.
- An assisted referral is specified by the receiving agency.
- For clarity and professionalism.

Adapted (with permission) from Marel C, Mills KL, Kingston R, Gournay K, Deady M, KayLambkin F, Baker A, Teesson M (2016). Guidelines on the management of co-occurring alcohol and other drug and mental health conditions in alcohol and other drug treatment settings (2nd edition). Sydney, Australia: Centre of Research Excellence in Mental Health and Substance Use, National Drug and Alcohol Research Centre, University of New South Wales.

Referrals are an important component of service delivery across all health and community-based treatment and support services. Referrals are the mechanism by which staff communicate with other agencies and support a patient to access services and transition between service providers. Comprehensive and consistent referral practices can support improved continuity of care, reduced duplication and promote seamless access to, and transfer between, HSPs, community-based AOD services and other community-based services including GPs. From a service perspective, established referral pathways support staff in helping patients/service users to achieve best health outcomes. They may also optimise service capacity by improving efficient utilisation of existing services [1].

Evidence demonstrates that effective patient engagement with AOD services on initial presentation has positive impacts on patient satisfaction, improves the likelihood of engagement with treatment and achieves positive health and wellbeing outcomes. Challenges accessing appropriate services are barriers that negatively impact on service engagement. Reports indicate that at times, patients/service users feel as though they are 'shuffled' between agencies or given multiple contact numbers and then left to navigate a complex system alone. Supporting patients/service users to navigate the system can be greatly improved through the implementation of streamlined referral pathways [1].

Driven by the principle that 'a self-referral is an empowering referral', the AOD sector broadly promotes patients/service users initiating self-referral for treatment. This places onus on the patient to take responsibility for his/her own journey while encouraging commitment and compliance. In some cases, reliance on self-referral by the referring body has reduced professional interaction at the interface between service providers and places responsibility solely on the patient to initiate and manage referrals throughout their engagement with each component of a complicated, siloed system [5].

While self-referrals are an appropriate option for many patients/service users and can be empowering for the individual, there are occasions where a formal written referral is either highly desirable or, as a matter of professionalism, obligatory. For some patients/service users, particularly those with co-occurring psychosocial issues, it is recommended to use active referral over passive referral both to support the patient in accessing the service and to ensure appropriate supporting information is provided to develop a shared understanding of the patient's goals and priorities. Referral should occur with the patient's informed consent and co-operation, including clear explanation of the reason for referral, expected outcomes and potential benefit to the patient's journey.

Active referrals are not the only strategy by which services can share patient information and promote continuity of care. Information sharing may still be relevant to the process of self-referral. With consent, services may wish to communicate information to support a patient who engages with a self-referral pathway.

Services are encouraged to consider their approach to both passive and active referrals and ensure that a range of pathways are in place to support timely, efficient communication and transition between services [5].

Chapter 4: Provision of Feedback

Communication on the outcome of referrals and shared care practices are a key strategy to promote consistency and support the appropriate sharing of patient information between services. MOUs, Service Level Agreements and the use of templates does not circumvent the need for direct communication between services. Rather it provides additional support to help facilitate interagency communication and promote timely, consistent and regular feedback and reduce demands on staff. Having the expectation and provision of feedback clearly outlined as part of an MOU or Service Level Agreement can help to support both agencies commitment to implementing and enhancing communication.[1]

HSPs are encouraged to work with their local community-based AOD service providers to implement referral pathways and feedback loops and to adapt these to include their local HSP communication procedures such as discharge summaries or review letters into the feedback provision. It is important to have common sense decision points along the feedback pathway to help guide at what stage of feedback would be appropriate to continue to provide.

Referral feedback can be provided in a number of ways such as via phone communication or electronically. The templates provided in this toolkit are suggested as a way of providing feedback that can be easily filed into patient records. Referrals and referral outcome/feedback forms and associated communication should be filed appropriately in the patient's medical record at every stage of feedback. These templates are a guide to support feedback provision and not expected to replace existing forms or processes where these already exist.

It is important to consider and include communication where appropriate and with patient consent, with carers/families, the patient's General Practitioner and nominated supports where appropriate along the referral and feedback pathway.

Practice Tips

Engaging General Practice

- HSPs are encouraged ensure AOD screening results, assessment and recommendations are included in patient discharge summaries to enable comprehensive follow up and support.
- Ensure correct identification of the patient's current GP and recheck this at each contact to enable appropriate communication and feedback.
- If a patient does not have a GP, clinicians should support patients/service users in engaging with a GP taking into consideration factors like location, opening hours, billing and specialities that will meet the patient's requirements.

4.1 Feedback Procedure

Stage One Feedback: Acknowledgement of Referral

HSP Outpatient/ Community Service	• Triage: Referral received and triaged as appropriate which may include contact with the patient, referral and other additional sources of information. • If a referral is not accepted, feedback should be provided including as required, supporting/facilitating a referral to the relevant service.
Community based AOD Services	• Acknowledgement of receipt of referral and feedback about relevant practice details such as intake process and timeframe of feedback re: outcome. • If the patient is not eligible or appropriate, feedback should be provided including information on a more appropriate service. It will remain the responsibility of the service (e.g. HSP referrer) to follow this up (unless specifically negotiated and agreed).

Stage Two Feedback: Outcome of Referral

HSP Outpatient/ Community Service	• Following Intake Meeting and/or Initial Assessment, outcome of referral will be provided to Community service referrer including information on mental health interventions/plan which may include any recommendations on other agencies or GP involvement.
Community based AOD Services	• Feedback on referral outcome within seven working days of the intake process. • This feedback will include the outcome of intake (including the service's decision to accept or decline the referral), waitlist information, if an initial assessment has been booked and date, and the patient's GP details. • It is encouraged to provide a copy of the feedback to their GP as well as any other organisations involved. • If the referral has been declined, the reasons and further actions required are to be outlined.

Stage Three Feedback: Commencement of Service

HSP Outpatient/ Community Service	• Feedback should be provided on the activation of the patient within the service stream (e.g. ATT, CTT, step up/step down service) within seven working days. • This may include the patient's Treatment, Support and Discharge Plan and Risk Assessment. • It is encouraged that a copy of this plan be communicated to all appropriate services identified by the patient including their GP.
Community based AOD Services	• Feedback relating to the outcome of referral will be provided within seven working days of the patient's initial assessment. • Feedback should include outcome of assessment and management plan including the nature and frequency (if relevant) of service to be provided, anticipated date of commencement of service and case manager/counsellor contact details. Additional information can include patient care plan, bloods etc. • It is encouraged that a copy of this plan be provided to the patient's GP to support continuity and seamless care, particularly as a patient may be discharged from the HSP and no longer receiving care, unless the referrer is an outpatient service of the HSP (e.g. mental health). Regardless, this information will be scanned into the patient's file and can help support appropriate assessment and treatment planning should the patient re-present.

Stage Four Feedback: Review or Completion of Service

HSP Outpatient/ Community Service	• For Shared Care Patients where appropriate joint clinical reviews are encouraged if able to be facilitated. • Provide a copy of the Recovery and Care plan review/GP letter (3 monthly) or at any points of significant change or alteration. • For Shared Care Patients, community-based AOD services should be involved in discharge planning and provided with a Discharge Summary or Transfer of Care Plan.
Community based AOD services	• Ongoing communication is encouraged on a regular basis (e.g. at 3 monthly reviews) or at any significant change/alteration in care such as the patient has entered rehab. • Joint discharge planning/meetings is encouraged for those patients/service users in shared care arrangements. • Feedback via completion forms or discharge summaries on completion of service within a timely manner (e.g. seven days). Feedback should include the rationale for change or cessation of care and a summary of ongoing support and management and any additional referrals.

Referral Feedback Example

A referral from an Emergency Department (ED) AOD team to CADS would likely benefit from Feedback Stage 1 and 2 and this information filed in the patient's/service users notes should they represent, however given the patient is no longer active or receiving care from an ED AOD team on an ongoing basis Feedback Stage 3 and 4 would likely not be appropriate and would be better suited to be communicated with that patient's GP to support ongoing care provision.

Alternatively, should the referral generate from an HSP Outpatient Service where the patient is receiving ongoing "shared care" such as outpatient hepatology/liver clinic or community mental health service then ongoing feedback through to Stage 4 would likely be appropriate.

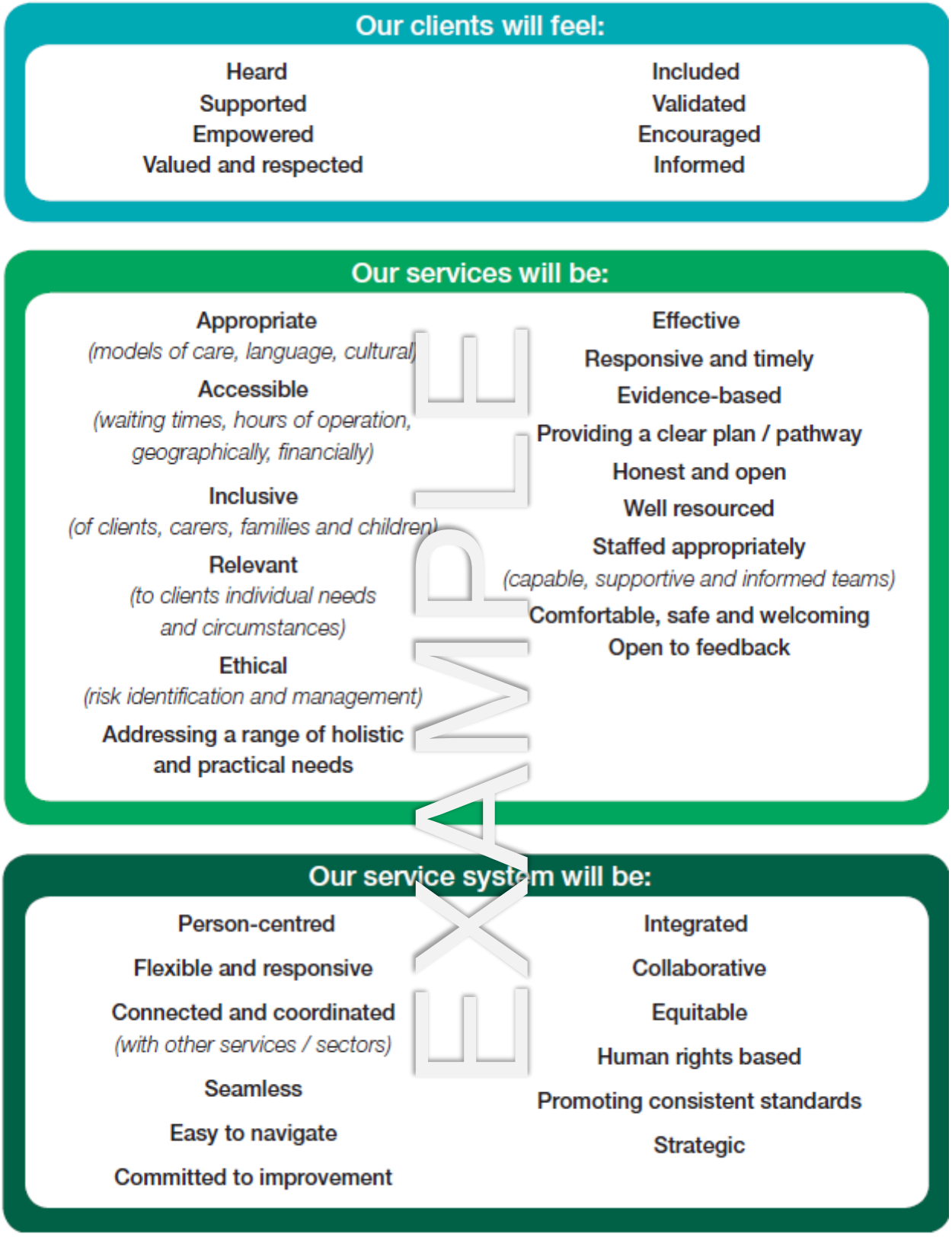
Referral and Feedback Provision Pathways are provided in Appendix 3 & 4.

A **Referral Feedback Template** is provided in Appendix 5.

Appendix 1: Shared Vision Example

Our vision for the Drug and Alcohol Sector

Staff working across Victoria's Eastern Region's Drug and Alcohol sector, have agreed upon the following principles as defining the way we seek to provide services for our community stakeholders.



EXAMPLE

Appendix 2: Memorandum of Understanding Template

Memorandum of Understanding

between

[*Hospital Service Provider*] and [*Community-based AOD service(s)*]

Background and Introduction

This MOU was developed to formalise an effective working relationship and shared care patient centred practices between the services and was initiated on [*date*].

[*Hospital Name*] is a [*tertiary/secondary/rural etc*] Hospital Service Provider in the [*North/South/East/WACHS metropolitan/regional*] Hospital Service Provider with [*number of*] beds and offers comprehensive health care services including [*descriptor of services*].

[*Community-based AOD service*] providing alcohol and drug treatment services across [*area*] WA. [*Community-based AOD service*] provides outpatient community-based treatment services for [*adults/youth*] including [*descriptor of services*]

The Western Australian Mental Health Commission together with non-government peak organisations, WA Network of Alcohol and Drug Agencies and WA Association for Mental Health have endorsed the development of formal linkages between local alcohol and drug and mental health services. The goal of such links is to facilitate coordination and shared care practices for the management of clients with alcohol or drug and Mental Health co-morbidities.

A number of patients/service users access both services with varying needs and complexities, including physical, mental health, AOD and social issues, and the parties wish to collaborate by working together to provide patient centred care with improved access and timely care to support patients/service users on their health journey.

1. Purpose

The purpose of this Memorandum of Understanding (MOU) is to:

- support liaison, communication, consultation and shared care practices between [*Hospital Service Provider*] *and* [*Community-based AOD service*]
- articulate the principles, protocols and functional working arrangements that will facilitate effective communication and collaboration between services
- support streamlined referrals, assessment and treatment processes in which all agencies work collaboratively in a patient-centred model of care
- support capacity building of both services and to provide a high standard of care, and
- provide clarification of the roles and responsibilities of participating organisations.

2. Scope

This document is a Memorandum of Understanding and shall not create binding or legal obligations to the parties. This agreement does not in any way replace, reduce, diminish or supersede any legal or ethical requirement or obligation, governance or management responsibility of any of the parties either jointly or singularly to this agreement.

3. Principles

- Enhance continuity of care for patients/service users.
- Improve patient access to, and transfer between HSP, AOD and community services including General Practitioners.
- Support patients/service users to negotiate care pathways.
- Improve patient outcomes by aiming to provide a seamless referral flow, improve service engagement and communication.
- Reduce need for patients/service users to provide duplicate information.
- Maximise efficiency in use of resources.
- Reduce demands on organisations through effective information sharing.
- Support the provision of quality, effective care through timely information gathering and sharing appropriate information.

The Parties have agreed to collaborate on the terms and conditions of this MOU.

4. Timeframe and Review

The MOU commences upon the execution of this MOU by all Parties and will be in place until such time that a relationship between the two services is no longer desirable or required by either party.

Any Party may terminate this MOU by giving 30 days written notice to the other Parties.

It is anticipated that the MoU will be reviewed [*timeframe/annually*] unless altered during the evaluation cycle.

5. Descriptor of Services

[*Community-based AOD service*] provides the following services:

[*Hospital Service Provider*] provides the following services:

[*Examples: Mental Health inpatient/outpatient services, AOD Consultation Liaison Services]*

6. Working Relationship Between Services

The relationship between services aims to achieve the following objectives:

- promote cohesive, collaborative and delineated care across two sectors
- ensure appropriate cross referrals and the provision of high-quality information
- promote open, regular and clear communication including outlining referral pathways, communication feedback loops and expectations between service staff
- facilitate ongoing service development
- ensure better outcomes for patients/service users by improved care delivery
- to identify and develop opportunities for joint delivery of clinical services to the target population
- to facilitate and promote skill development for staff working within the Alcohol and Drug services.

7. Key Contacts

[*Community-based AOD service*] key contact/s: [ ]

[*Hospital Service Provider*] key contact/s: [ ]

Key contact/s can facilitate links for communication, joint care planning, complex case discussions or areas of improved working relationships.

8. Referral Pathways and Provision of Referral Feedback

The partnership services support processes required to provide high quality, consistent and effective information sharing. Provision for on-referral and feedback following referrals will be achieved through pathways detailed in Appendix [*X*].

Regular meetings, at an agreed time, will take place between [*Hospital Service Provider*] and [*Community-based AOD service*] identified staff (management and relevant service AOD clinicians) to ensure regular communication, liaison and feedback between the services.

9. Collaborative Staff Development Training and Initiative

[*Outline the sector's potential training opportunities, for example:*]

- *Ensure new staff to each service are made aware of each other's services and referral pathways during induction training.*
- *Promote each other's training calendars and make staff training and education accessible across sectors.*
- *Support and promote staff placements across the sectors at a local level, facilitating staff to gain experience within each of the sectors; within human resource guidelines, limitations and demands. This will enhance staff knowledge, skills and confidence and promote a better understanding of local AOD and Mental Health Services.*
- *Include staff from both sectors in any local dual diagnosis training related network meetings, including presentations and training forums.*

10. Confidentiality

All parties acknowledge that they are bound by the provisions of the Privacy Act 1988 and shall comply with their obligations under the Act including collection and disclosure of personal information. All parties agree that the MOU provides the opportunity to share information between the parties, where appropriate.

Patient consent for sharing of information between partner agencies should be recorded using the appropriate consent forms. Where consent for release of information is not given, patients/service users will be made aware that this may reduce the effectiveness of the care provided and should be reviewed regularly. In some circumstances, issues of patient safety or public protection may override the patient's request for confidentiality.

11. Costs

Costs associated with staffing costs, vehicle and administrative costs are to be met by the individual partner agency unless otherwise negotiated.

12. Dispute Resolution

All parties are committed to resolving compliance, conflict and clinical issues in a timely and respectful manner, utilising contemporary dispute resolution practices. Matters that cannot be resolved amongst members of the key partner agencies may be referred to each of the respective agencies' senior management teams.

13. Application of this MOU

This MOU applies to HSP and Community Alcohol and Drugs Service Providers for the entire Collaboration between the Parties. This MOU replaces any previous agreement executed by the parties in respect of this Collaboration.

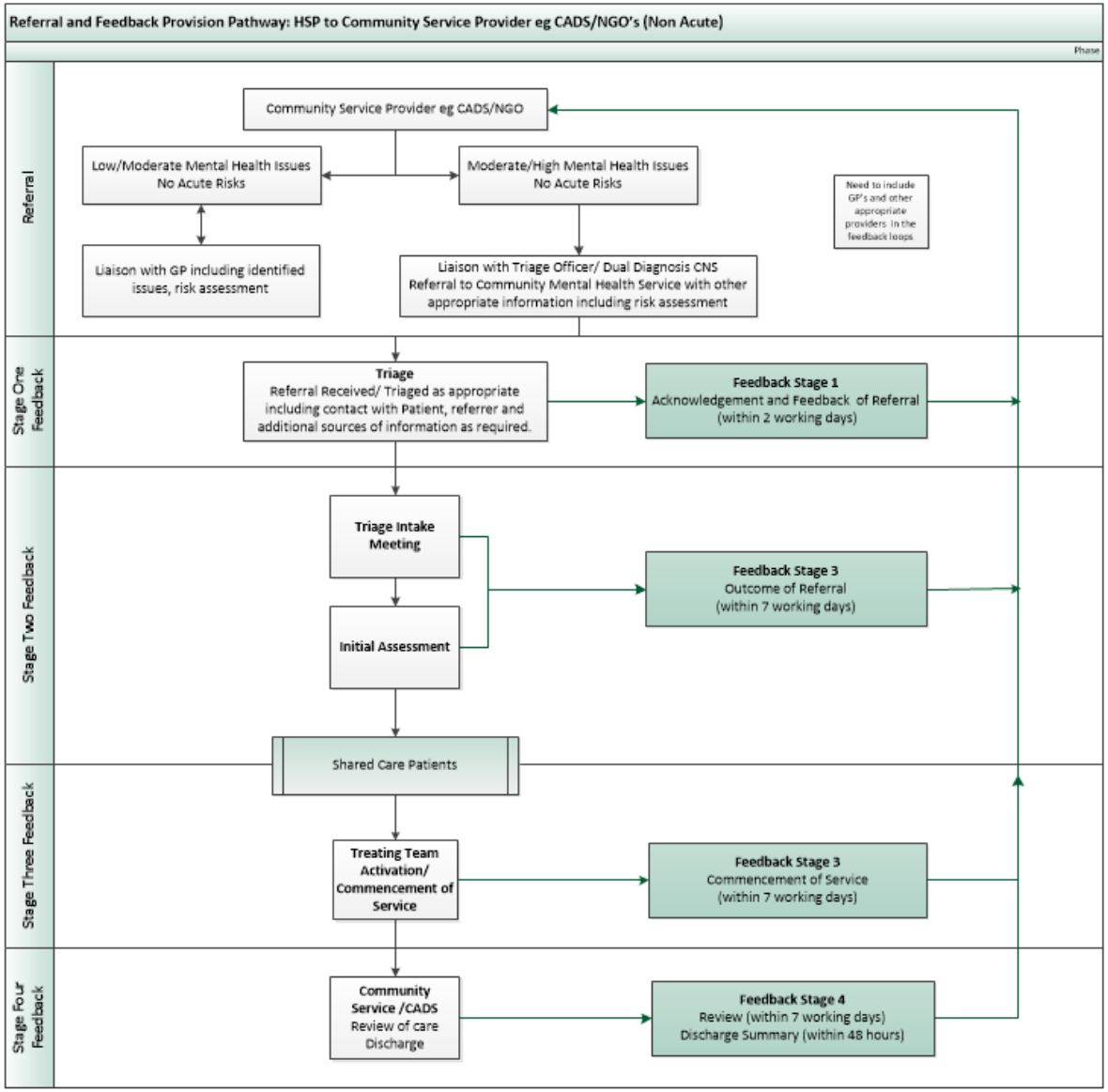
14. Guiding Documents

15. Signatories

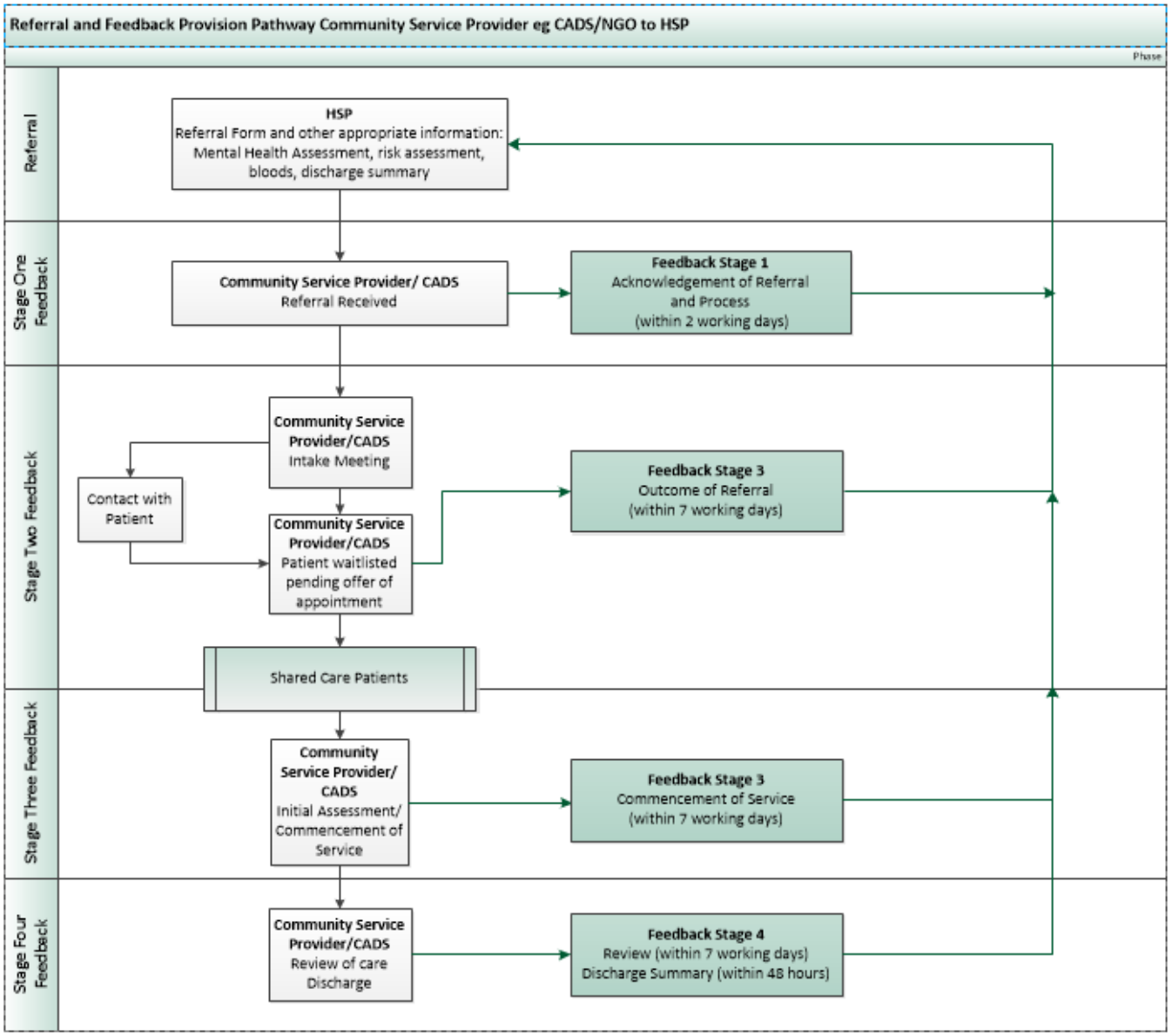
16. **Appendices –** e.g. referral forms, pathways, communication feedback templates, staff placement guidelines.

Example provided based on MOUs from Cyrenian House and SMHS / SMCADS.

Appendix 3: Hospital to Community Service Provider Referral and Feedback Pathways



Appendix 4: Community Service Provider to Hospital Referral and Feedback Pathways



Appendix 5: Referral Feedback Template

"Engage with me, and **help me on my journey**"

INSERT BARCODE HERE				
	SURNAME	UMRN		SERVICE NAME
	GIVEN NAMES	DOB	GENDER	
	ADDRESS	POSTCODE		CONTACT DETAILS
		TELEPHONE		
	COMPLETE ALL DETAILS OR AFFIX PATIENT LABEL HERE			

Referral Received on (Date)		
Referrer Details and Organisation		
Self Referral ☐	Active Referral ☐	Other ☐

Stage 1 Feedback

Referral has been received ☐	Date
The referral will be processed through our intake meeting and you will receive further communication regarding the outcome within [1-2 business days]	
Additional Information: e.g. any further information requested bloods, discharge summary	

Stage 2 Feedback

Referral has been **Accepted** ☐		Date
Client Placed on Waiting List ☐	Approximate Waiting Time	
Initial Assessment Booked ☐	Date of Initial Assessment	
General Practitioner Copy provided to GP ☐	Carer/Family Communication ☐	
Key Contact	Other Organisations Involved	
Referral has been **Declined** ☐		Date
Wrong Place ☐ Referral forwarded to	Client Declined ☐	Other ☐
Comments and any further actions required:		

Stage 3 Feedback (Shared Care)

Initial Assessment ☐ Date			Commencement of Service ☐ Date	
Nature of Service Delivery	Medical ☐	Counselling ☐	Withdrawal ☐	Rehab ☐
General Practitioner Copy provided to GP ☐			Case Manager/Counsellor Contact Details Carer/Family Communication ☐	
Service Not Provided ☐		Date		
Client Declined ☐	Service No Longer Required☐		Other ☐	
Additional Information: e.g. additional referrals made, attached care plan, additional information required, medication changes made, blood test results				

Level 4 Feedback (Shared Care)

Review Communication (3 monthly) ☐	Date
Service Provision Completed ☐ Copy provided to GP ☐	Change of Service Delivery ☐ Carer/Family Communication ☐
Client Plan:	

References

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