GUIDELINES FOR EFFECTIVE INPATIENT CONSULTATION
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In simple terms, a consult is a request made from one physician or provider to another physician or provider to give an opinion or advice on a specific patient. A consultation is usually sought when a physician or provider with primary responsibility for a patient recognizes conditions or situations that are beyond his or her training or expertise. An effective consult should always be performed with the patient's best interest in mind and have a positive impact on the patient's care. Open communication between the referring physician or provider and the consult provider is essential for effective consultation.

Guidelines for Referring Physicians/Providers Requesting Consultation

1. **Ask a clear and specific question.**
    - Don't make the consultant guess what your question is. A vague question will likely result in a vague response;
    - Referring physicians/providers are encouraged to contact the consultant directly to clarify the question to be addressed;
    - If the referring physician/provider is interested in arranging a procedure (endoscopy, bronchoscopy, etc.), he or she should make that request clear to the consultant;
    - A request for a consult should be placed in IMPACT and/or documented in the medical record.
2. **Establish the degree of urgency.**
    - The referring physician/provider must decide if the consult should be seen *emergently* (immediately), *urgently* (same day), or *routinely* (within 24-48 hours). Underestimating the urgency of the consultation may negatively impact patient care; repeatedly overstating the urgency may annoy the consultant.
3. **Call the consult early.**
    - Call *early in the day* to allow the consultant the best opportunity to see the patient the same day;
    - Call *early in the week*, especially if attempting to schedule specialized procedures or diagnostic studies not routinely performed on weekends;
    - Call *early in the hospital course*; calling a consult on the day the patient is scheduled for discharge reflects poor planning and may not allow the consultant to make effective interventions.
4. **Physician-to-physician/provider communication is critical!**
    - Don't delegate the responsibility of calling a consult to anyone who is not fully familiar with all details of the patient's case;
    - If the referring physician/provider calls the consultant directly, the consultant is much more likely to return the favor after the patient has been evaluated.
5. **Provide essential medical information.**
    - In all but emergent circumstances, the consultant should reasonably expect to find a complete admission history and physical examination for the patient entered in the medical record;
    - In particular, the referring physician/provider should provide critical details that may not be immediately available to the consultant (e.g., information from outside hospitals).

6. **Notify the patient to expect a visit from the consultant.**
   - The referring physician/provider should always discuss plans for consultation with the patient to be sure that the patient is in agreement and to avoid any misunderstandings.
7. **Acknowledge the recommendations provided by the consultant.**
   - The referring physician/provider has the option to accept or reject the consultant's recommendations. However, if the referring physician/provider elects not to implement the consultant's recommendations, he or she should, at least, acknowledge in the medical record that the consultant's recommendations have been received and reviewed.
8. **Avoid "curbside" consultation except for simple, straight-forward problems.**
   - "Curbside" consultation is best suited for questions with a factual answer that can be looked-up quickly in a reference source (e.g., drug dose, lab test interpretation, etc.). For more complex questions, a request for formal consultation is more appropriate;
   - Be willing to request formal consultation if that is suggested by the consultant;
   - "Curbside" questions should ideally be discussed between attending physicians/providers without involvement of trainees or other personnel.
9. **If co-management of the patient is desired, the referring physician/provider should discuss that directly with the consulting physician/provider.**
   - The patient's attending physician remains in charge of the patient's overall care, but can delegate specific aspects of management to the consultant, if mutually agreeable;
   - Co-management should not be assumed or presumed by either party. If the referring physician and consultant agree on co-management, the boundaries should be carefully defined and entered into the medical record by the referring physician.
10. **Discuss the consultant's findings and recommendations with the patient.**

Guidelines for Physicians Providing Consultation

1. **Answer the question that was asked.**
   - Don't be distracted by other interesting findings that are outside of the scope of the original question;
   - If the consultant uncovers other previously-unrecognized clinical problems that need to be addressed, the consultant should call the referring physician to discuss them further.
2. **See the patient in a timely manner.**
   - When the consult is called, establish the degree of urgency with the referring physician/provider;
   - As a general rule, all consults called to UAB Department of Medicine services should be seen and staffed within 24 hours, whenever possible;
   - All UAB DOM Divisions providing consultative services must make arrangements to provide consults on nights, weekends, and holidays when requested.
3. **Make certain that the recommendations are clear and easy for the referring physician/provider to understand.**
   - Be concise and succinct; use definitive language;

- Recommendations offered in a list are easier to follow than recommendations buried in paragraphs of text;
- When the diagnosis is uncertain, listing every possible differential diagnosis is not helpful. Offer the top 5 possibilities;
- Prioritize your recommendations. Make clear which recommendations are critical, which should ordinarily be 5 or fewer. Other recommendations can go on a "non-critical" list.
- Indicate which (if any) of the recommendations will be carried out by the consulting team
- Be very specific and offer detailed recommendations. The referring physician/provider should not be expected to have the consultant's level of expertise. Clearly define drug doses, routes of administration, frequency and duration of dosing, specific tests to be ordered, etc.
- For handwritten notes, legibility counts. Recommendations that cannot be deciphered are not helpful and carry potential for harm.
- (Temporary recommendation – during the transition from paper to electronic medical records, potential exists for a consult note to be overlooked because it is in the "other" location. During the transition period, a consultant who leaves a note in the paper chart should add a notation in IMPACT to "see chart for recommendations." Conversely, a consultant writing a note in IMPACT [or Horizon] should leave a notation in the paper chart to "see IMPACT [or Horizon] note for recommendations.")

4. **Physician-to-physician/provider communication is critical!**
   - A telephone call from the consult attending/provider is usually appropriate and appreciated by the referring physician/provider. When the consult contains "critical" recommendations that need to be implemented as soon as possible, direct physician-to-physician/provider communication is essential;
   - Never leave "critical" recommendations in the medical record without notifying the referring physician/provider;
   - In less-critical situations, communication by other team members (e.g., resident to resident) may be acceptable.
5. **The consultant's note should be professional and respectful in language and tone.**
   - An effective note should be informative without being patronizing and should be helpful without being condescending;
   - A consult note is not an appropriate place to offer criticism of other providers, services, or institutions;
   - "Chart wars" are counter-productive and should always be avoided; providers who disagree on management plans should discuss their differences of opinion directly.
6. **The consultant should first discuss his or her findings and conclusions with the referring physician/provider, not with the patient.**
   - Remember that the consultant's recommendations may or may not be implemented by the referring physician/provider. Don't confuse the patient;
   - If the consultant suspects a diagnosis with high potential for emotional impact (e.g., a new diagnosis of cancer), the consultant and the referring physician/provider should discuss who is in the best position to break this news to the patient.

7. **Continue to see the patient as frequently as required until the medical issue has been satisfactorily resolved.**
    - The appropriate frequency of follow-up depends on the severity and pace of the problem under evaluation;
    - When further follow-up is no longer necessary, the consultant should enter a formal "sign off" note into the medical record.
8. **Arrange subspecialty outpatient follow-up, when necessary and requested by the referring physician/provider.**
9. **Define parameters for co-management when requested by the referring physician/provider.**
    - A consultant should never assume a co-management role unless specifically requested to do so by the referring physician/provider. If the referring physician/provider requests that a consultant take over management of specific aspects of the patient's care, the parameters should be carefully defined in a conversation and documented in the medical record;
    - Identify the contact person from the consulting team who will be writing the co-management orders and enter that information in the medical record.
10. **Accept requests for "curbside" consultation only when the issue is simple, straight-forward and clearly within the consultant's area of expertise.**
    - For questions where decision making is more complex, the consultant should not hesitate to suggest formal consultation and offer to see the patient;
    - "Curbside" questions are ideally discussed between attending physicians. Trainees should not offer "curbside" opinions without first reviewing the question with the attending consultant.