Letters

Letters are form of communication to update clinicians of what happened during a patient encounter.

If a patient had multiple encounters across a hospital stay, the patient will have a communication letter per encounter during that stay.

Sample Scenario:
A patient goes to ED to seek treatment. After tests and assessment, it was identified that patient's concern is not emergency and was referred to SDEC. SDEC sees the patient and determines that patient may go home however patient will need to do SDEC follow up after two days. Patient attends SDEC follow up after which SDEC team decides that he can be discharged from their service.

How many letters will the patient receive?

Answer:
Three

Letter 1: **ED Letter** containing events that happened during the ED encounter and that the patient was referred to SDEC. (If the patient was admitted, it will then state that patient was then admitted to ward/hospital)

Letter 2: **SDEC Letter** containing events that happened during the SDEC encounter. SDEC will also include that a referral was made for an SDEC follow up.

Letter 3: **SDEC Follow Up Letter** containing events that happened during the SDEC follow up. SDEC will state that the patient is discharged from their service.

Considerations:

- If a patient is admitted to ward / hospital then goes home, GP will receive a discharge summary.

- If there were changes done to a previously sent discharge summary to a GP, this will trigger another discharge summary to be sent to the GP once system built-in triggers are activated (patient discharged from hospital or discharge note signed).

- If a patient is seen in ED by a specialty, however, the specialty declines the consult, ED will write discharge letter.

- If a patient is seen in ED by a specialty and the specialty thinks that the patient doesn't need to be admitted, however, will need to see the specialty's clinic as outpatient. The specialty then writes the discharge letter and includes details of the follow up to their specialty clinic.