

Communicating Diagnostic Test Results to Patients

Introduction

Patients deserve to receive their test results and an adequate explanation of the results in a timely manner. The failure to do so can cause unnecessary worry and, in some cases, lead to serious consequences for the patient.

In 2011, the Commission issued a guideline on the ["Transmission of Time Critical Medical Information"](#) focusing on practitioners' obligation to communicate critical test results to other practitioners. The Commission issues this guideline to assist practitioners communicating test results directly to patients. The term "test results" in this guideline refers to diagnostic test results.

Guidelines

All practitioners should have an effective system that will ensure timely and reliable communication of test results to patients and appropriate follow up. While the system will vary depending on the type of practice, the Commission recommends that it be in writing and, at a minimum, contain the following elements:

1. Clear definitions to distinguish between test results that are routine and test results that are critical.
2. A mechanism by which the ordering physician is notified of the receipt of critical test results from the diagnosing physician.
3. A process to communicate the test results to the patient in a timely manner—whether in writing, electronic, telephonic or in person—that ensures the patient receives the test results.
 - a. The communication should be in a format and in language that is easily understood by the patient.
 - b. The medical record should reflect who made the communication, how the communication was made, and when the communication was made.
 - c. The communication should comply with the privacy requirements of the Health Insurance Portability and Accountability Act and Washington State law.
4. Confirmation that the patient received the test results. Verification of receipt should be documented in the medical record.
5. Clear instructions to the patient to enable the patient to contact the practitioner and ask questions about the test results and schedule a follow up appointment with the practitioner. The instructions should be documented in the medical record.

6. If the test results indicate that treatment may be necessary, the ordering practitioner should discuss potential options with the patient and initiate treatment.
7. When the ordering practitioner is unavailable, there must be a qualified designee who will assume responsibility to receive test results, notify the patient, and initiate appropriate clinical action and follow up.
8. The system should not depend solely on the attentiveness of human beings, but be backed up by technology that prevents test results from being missed, lost or inadequately communicated to the ordering physician or to the patient.

Resources

Communicating Test Results to Providers and Patients, Department of Veterans Affairs, Veterans Health Administration, VHA Directive 1088. October 7, 2015.

file:///doh/user/fr/mlf1303/Desktop/1088_D_2015-10-07.pdf

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