



Non-contact clinical time

Inbox management

- Repeat scripts
- Portal messages (MMH etc)
- Email enquiries
- Personal inbox
- Clinic inbox
- Random emails
- Specialist letters
- Other health professionals' letters
- Urgent care consult summaries
- Notes request
- Lab and radiology results

Review of:

- Patients seen by nurse
- Patients seen by registrar
- HIP and HC actions
- Medication reconciliation
- Clinical audits
- Providing second opinions
- Old notes or referrals from specialist GPs or others in primary care

Meetings with MDT/ GPs/other clinical staff

- Planning
- Updates on patient progress
- Care co-ordination (e.g. discussions with allied health and/or nursing staff)
- Rapid rounds

Follow-up

- Writing consultation notes
- Lab results – screening, bloods
 - Checking/flagging
 - Follow up/chasing
 - Advising patient
- Notes reviews
- Researching things for patients
- Referrals
 - Making
 - Checking
 - Rescheduling
- Writing drug charts and discharge scripts
- RHM referrals
- Receiving phone referrals from other MDT members
- Phone consults with other specialists
- Written consults (ERMS or consult requests) for other specialists

Transfers



- Patients transferring into/out of practice
- Sending notes to non-registered patients' own doctor
- Discussions and organising transport of critically unwell patients
- Reviewing patients transferred back from a base hospital
- Following up outcomes for patients you have transferred to a base hospital

Reports/forms/letters

- Insurance
- Employment
- Firearms, diving, boxing, other sports
- WINZ
- Housing NZ
- Coroners
- ACC
- Cannabis clinics
- Lawyers
- Police

Hospital contacts

- EDs
- OP letters
- Investigations
- Discharge summaries
- Calling other specialists/health providers

Other

- Med charts for respite care or DNAs
- Enduring power of attorney – this requires an in-person assessment of patient as well as detailed paperwork
- Viewing deceased patients before completing cremation form