LEGAL NOTICE NO. 2

THE MEDICAL PRACTITIONERS AND DENTISTS ACT

(*Cap.* 253)

IN EXERCISE of the powers conferred by section 23 of the Medical Practitioners and Dentists Act, the Cabinet Secretary for Health, after consultation with the Board, makes the following Rules:—

THE MEDICAL PRACTITIONERS AND DENTISTS (REFERRAL OF PATIENTS ABROAD) RULES, 2017

Citation.

1. These Rules may be cited as the Medical Practitioners and Dentists (Referral of Patients Abroad) Rules, 2017.

Interpretation.

2. In these Rules, unless the context otherwise requires—

"abroad" means outside the borders of Kenya;

"medical management" means medical interventions including diagnosis, treatment and follow up;

"receiving facility" means an institution or hospital outside Kenya where a patient has been referred to; and

"referral" means the transfer of a patient from one hospital or practitioner to another for purposes of consultation, treatment, review or further action.

Referral of patients abroad.

3. (1) A medical or dental practitioner may refer a patient for medical or dental management abroad where—

(a) there is evidence that there is inadequate expertise or medical facilities to handle the condition locally;

(b) there is evidence that the referral would be the most cost effective option for the patient, or

(c) the patient has opted to seek medical intervention or management abroad where public resources are not used.

(2) Save wherein a patient consents, a medical or dental practitioner shall not be compelled to give information regarding a patient to third parties for purposes of referral.

Qualification and Responsibility of the referring practitioner.

4. The referring medical or dental practitioner shall—

(a) be duly registered and licensed by the Board and of good standing;

(b) be a specialist or sub-specialist in the area in which the patient is being referred for;

(c) act in the best interest of the patient;

(d) ensure that there shall be significant health benefits to the patient in seeking treatment abroad;

(e) ensure that the referral is for curative, specialized diagnostic purposes or rehabilitative services;

(f) provide the patient or guardian with relevant information on the expected treatment; and

(g) ensure an appropriate review and follow up mechanism is established upon the patient's return.

Category and accreditation abroad.

5. A medical or dental practitioner shall refer a patient for treatment abroad to—

(a) a medical or dental practitioner who has the requisite recognized credentials to offer the level of the required specialized service;

(b) a receiving institution that has recognition from the regulatory authority of the receiving country to offer the required service;

(c) a receiving institution that is above or the equivalent to a Level 5 or Level 6 category facility in Kenya; or

(d) a receiving institution that has recognized international accreditation.

Referral process.

6. (1) A medical or dental practitioner shall refer a patient abroad in the Referral Form set out in the Schedule.

(2) The Referral Form shall be accompanied by—

(a) a comprehensive medical report by the referring practitioner;

(b) a letter of confirmation from the receiving facility;

(c) a letter of no objection from the Office of the Director of Medical Services; and

(d) proof of adequate funding.

Professional misconduct.

7. A practitioner shall be culpable of professional misconduct if such practitioner—

(a) refers a patient where the health outcome will not improve;

(b) discloses information acquired in the course of professional engagement to an unauthorized third party without the consent of the patient, or otherwise than required by law; and

(c) refers or agrees to refer a patient for personal and/or financial gain.

SCHEDULE (r. 6(1))

THE MEDICAL PRACTITIONERS AND DENTISTS ACT

(*Cap*. 253)

REFERRAL FORM FOR MEDICAL MANAGEMENT ABROAD

PART A—To be filled by the patient

i. BIO DATA OF THE PATIENT

Surname: ……..……First name…….....……

Other name(s):…….....……

ID/Passport No: …….....……..Date of Birth: ….....……

Age:…….. Gender: ∈ Female ∈ Male

P.O. Box …….....…… Code…….....….. Town ……..……..…

County…….....……

Email address…….....……..……..……

Telephone No. …….....…… Mobile No. …….....……..

Source of funding (Tick(✓)where appropriate)

- ☐ Self-funded
- ☐ National Hospital Insurance Fund
- ☐ Private Insurance
- ☐ Government sponsored
- ☐ Other, specify ……...……

……....……

……....…….....……

ii. DETAILS OF THE NEXT OF KIN

Surname: …….....……. First Name: ….…….....…….…..

Other name(s): …….....……..….

ID/Passport No: …….....……. Date of Birth: …….....……

Relationship…….....……..……

P.O. Box…….....…… Code…….....…… Town…….....…..……

County…….....……

Email address ……..……

Telephone No…….....…… Mobile No…….....……

iii. DETAILS OF THE ACCOMPANYING CARE-GIVER (If different from B above)

Surname: …….....…….. First Name: …….....……

Other name(s):……

ID/Passport No: ……..…Date of Birth: ……

Relationship……

P.O. Box…… Code……..……Town……

County……

Email address ……..……

Telephone No…… Mobile No……..……

iv. DETAILS OF THE DONOR (Where Appropriate)

Surname: ……..……. First Name: ……..……

Other name(s): ……..……

ID/Passport No: ……..……Date of Birth: ……..……

Relationship……..……

P.O. Box……..……Code……..……Town……...……

County……..……

Email address …..……..……..……

Telephone No……..…… Mobile No……..……

v. DECLARATION

I …… hereby declare that the information given above is true to the best of my knowledge and belief.

Signature:……..……...……

Date……..……..

PART B—To be filled in by the Referring Practitioner

(a) MEDICAL DETAILS OF THE PATIENT

(1) Provisional diagnosis ……...……

……..……

……..……

……..……

(2) Reason for referral: ……..……..……

……..……..……

……..……..……

(3) Expected Treatment

……..……..……

……

……

(4) Expected Outcome

……

……

……

(5) Plan for review and follow-up upon return of the patient to the country.....

……

……

……

(b) DETAILS OF THE RECEIVING FACILITY/PRACTITIONER

1. Receiving Facility

Name of facility:.....

……

……

City: ……..…… Country: ……..……

Physical address: ……..……

……..……..

Postal address:.....

……..……..……

……..……..

E-Mail:……..……..……..

Telephone/Mobile No…….

2. Practitioner/Contact Person:

Name:……..……..

Qualification:……..……

E-mail address……..……

Telephone/Mobile No……..……..……

(c) CERTIFICATION BY THE REFERRING PRACTITIONER

Details of referring practitioner:

Surname: ……..…… First Name: ……..……

Other name(s):……..……..

Qualification.....

Specialty…….....……

Sub-specialty…….....……..

Reg. No:……..... License No:……

P.O. Box…….....…….Code…….....…Town……...……

County…….....……...

Email address…….....……

Telephone No…….....…… Mobile No…….....……

I certify that the information given in Part A and B regarding Mr/Mrs/Ms/Mst……is true to the best of my knowledge and belief.

Signature: …….....…….

Date……..…….....……

PART C—To be filled in by the Kenya Medical Practitioners and Dentists Board

I wish to confirm that Dr. ……..….. is registered under Registration Number…….....……., validly licensed under current License No:…….....……..and is of good standing.

Name…….....…Signature…….....……Date….....……

Chief Executive Officer

Kenya Medical Practitioners and Dentists Board

PART D - To be filled in by the Director of Medical Services

Approval is hereby given for..... who has been referred by Dr.....to travel abroad for medical/dental management in..... (country).

Name…….....……Signature…….....……Date…….....…

Director of Medical Services

Made on the 9th January, 2017.

CLEOPA MAILU,
Cabinet Secretary for Health.