



Potential Quality Issue (PQI) Referral Form

Risk Manager Confidential Fax:
954-251-4161

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Section I				General Information			
Member Name:					DOB:		
Sex:		Product:	<input type="checkbox"/> MMA <input type="checkbox"/> FHK <input type="checkbox"/>		ID#:		
Provider:					Provider #:		
Referred By:					Date:		
Dept./Office:					Phone:		
Section II				QI Department Only			
Received By:					Date Received:		
Area Office:					Date Forwarded to		
Section III				GOSI (Deliver Report to Quality Dept. within 5 days)			
<input type="checkbox"/> Unexpected admissions or complication of admission due to delay or quality issue regarding outpatient management							
<input type="checkbox"/> Unexpected Readmission within 30 days (post-op complication or same diagnosis, not cancer or hospice)							
Readmission Diagnosis:							
<input type="checkbox"/> Delay in access: <input type="checkbox"/> PCP <input type="checkbox"/> Specialist <input type="checkbox"/> Treatment							
<input type="checkbox"/> Primary cancers advanced: <input type="checkbox"/> Breast <input type="checkbox"/> Colon <input type="checkbox"/> Cervical <input type="checkbox"/> Prostate							
<input type="checkbox"/> Obstetrical (OB) Complication							
<input type="checkbox"/> Delay or Missed Diagnosis							
<input type="checkbox"/> Other							
Section IV				Adverse Incident (Report to Risk Management within 24 hours)			
<input type="checkbox"/> Unexpected Enrollee Death				<input type="checkbox"/> Permanent Disfigurement			
<input type="checkbox"/> Enrollee Brain damage or Spinal damage				<input type="checkbox"/> Fracture or dislocation of bones or joints			
<input type="checkbox"/> Enrollee Elopement				<input type="checkbox"/> Any condition that extends the patient's length of stay			
<input type="checkbox"/> Any condition requiring definitive or specialized medical attention which is not consistent with the routine management of the patient's case or patient's pre-existing physical condition.				<input type="checkbox"/> Any condition that results in a limitation of neurological, physical, or sensory function which continues after discharge from the facility			
<input type="checkbox"/> Any condition that required transfer of the patient, within or outside the facility, to a unit providing a more acute level of care due to an adverse incident				<input type="checkbox"/> Any condition requiring surgical intervention to correct or control (i.e. foreign body, return to surgery)			
Date faxed to Risk Management:							
Sender - Print Name:				Signature:			



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Section V				Occurrence Information	
Member Name:			Member ID:		
Date of Occurrence:			GOSI Code #:		
Description of Occurrence:					
Medical Director Only					
Level Assigned*:	<input type="checkbox"/> Level I	<input type="checkbox"/> Level II	<input type="checkbox"/> Level III	Date Reviewed:	
Recommendation:					
MD/DO Signature:		Print Name:		Date:	
* Legend:	Level 1- Acceptable Medical Care Provided, No Further Review Needed Level 2- Opportunity for Improvement in Medical Care Provided Level 3- Medical Care Falls below the Standard of Medical Practice				
Section VII	Risk Management			Referred Date:	
Risk Manager Evaluation:					
Actions: <input type="checkbox"/> None Required <input type="checkbox"/> Legal/Adm. <input type="checkbox"/> CAP <input type="checkbox"/> Other:					
Signature:		Print:		Date Closed:	