Community Care Plan
The Health Plan with a Heart

# Potential Quality Issue (PQI) Referral Form

Risk Manager Confidential Fax:
954-251-4161

**CONFIDENTIAL—DO NOT COPY (Please type or print clearly)**

| **Section I** | **General Information** | | | | | |
|---|---|---|---|---|---|---|
| Member Name: | | | | | DOB: | |
| Sex: | | Product: | ☐ MMA ☐ FHK ☐ | | 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)*** |
|---|---|
| ☐ | Unexpected admissions or complication of admission due to delay or quality issue regarding outpatient management |
| ☐ | Unexpected Readmission within 30 days (post-op complication or same diagnosis, not cancer or hospice) |
| | Readmission Diagnosis: |
| ☐ | Delay in access: ☐ PCP ☐ Specialist ☐ Treatment |
| ☐ | Primary cancers advanced: ☐ Breast ☐ Colon ☐Cervical ☐ Prostate |
| ☐ | Obstetrical (OB) Complication |
| ☐ | Delay or Missed Diagnosis |
| ☐ | Other |

| **Section IV** **Adverse Incident** ***(Report to Risk Management within 24 hours)*** | |
|---|---|
| ☐ Unexpected Enrollee Death | ☐ Permanent Disfigurement |
| ☐ Enrollee Brain damage or Spinal damage | ☐ Fracture or dislocation of bones or joints |
| ☐ Enrollee Elopement | ☐ Any condition that extends the patient's length of stay |
| ☐ 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. | ☐ Any condition that results in a limitation of neurological, physical, or sensory function which continues after discharge from the facility |
| ☐ 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 | ☐ 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*: | ☐ Level I ☐ Level II ☐ Level III | Date Reviewed: |
| Recommendation: | | |
| **MD/DO Signature:** | **Print Name:** | **Date:** |
| *** Legend:** | Level 1- Acceptable Medical Care Provided, No Further Review Needed<br>Level 2- Opportunity for Improvement in Medical Care Provided<br>Level 3- Medical Care Falls below the Standard of Medical Practice | |

| **Section VII** | **Risk Management** | Referred Date: | |
|---|---|---|---|
| Risk Manager Evaluation: | | | |
| Actions: ☐ None Required ☐ Legal/Adm. ☐ CAP ☐ Other: | | | |
| Signature: | Print: | Date Closed: | |