Communitycare the health plan with a heart PLAN	**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	☐ Fracture or dislocation of bones or joints
☐ Enrollee Spinal damage	☐ 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 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: ☐ None Required ☐ Legal/Adm. ☐ CAP ☐ Other:

Signature:	Print:	Date Closed: