



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"/> CMS19	<input type="checkbox"/> CMS21	ID#:
Provider				Provider #:	
Referred By:				Date:	
Dept./Office:				Phone:	
Section II				QI Department Only	
Received By:			Date Received:		
Area Office:			Date Forwarded to MD:		
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			<input type="checkbox"/> Fracture or dislocation of bones or joints		
<input type="checkbox"/> Enrollee Spinal damage			<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
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Member Name:	Member ID:
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Date of Occurrence:		GOSI Code #:	
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Description of Occurrence:	
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Medical Director Only

Level Assigned*:	<input type="checkbox"/> Level I <input type="checkbox"/> Level II <input type="checkbox"/> Level III	Date Reviewed:
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Recommendation:	
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MD/DO Signature:	Print Name:	Date:
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* 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
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Section VII	Risk Management	Referred Date:	
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Risk Manager Evaluation:

Actions: <input type="checkbox"/> None Required <input type="checkbox"/> Legal/Adm. <input type="checkbox"/> CAP <input type="checkbox"/> Other:

Signature:	Print: Susan Ragazzo RN BSN LHCRM	Date Closed:
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