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	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)***

- ☐ 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**	
Date of Occurrence:		**GOSI Code #:**	
Description of Occurrence:			

	Medical Director Only
Level Assigned*:	□ Level I □ Level II □ Level III Date
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**	Referred Date:	

Risk Manager Evaluation:

Actions: □ None Required □ Legal/Adm. □ CAP □ Other:

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