

This Potential Quality Issue (PQI) Referral Form may be subject to state law provisions pertaining to confidentiality protections, attorney-work product, and other types of privilege. All documents, reports, and information relating to the review of a PQI are kept confidential in accordance with peer review protection.

Potential Quality Issue (PQI) Referral Form

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*Fill out Sections 1, 2, and 3
Secure Fax to 205-994-7579*

Section I		General Information		
Date of referral		Time		
Member name		DOB	Sex	
LOB		Member ID#		
Provider name		Provider #		
Facility name		Facility location		
Name of person submitting referral		Department and title		
Contact information				
Section II		Potential Quality Issue (Must check at least one)		
Suspected Category	Suspected Type			
Diagnosis Error	<input type="checkbox"/> Misdiagnosis <input type="checkbox"/> Missed diagnosis			
Medication Error	<input type="checkbox"/> Prescribing wrong or contraindicated medication <input type="checkbox"/> Administration of wrong medication, wrong dosage, or by wrong route <input type="checkbox"/> Failure to administer medication <input type="checkbox"/> Adverse event related to high-risk medication			
Evaluation and Treatment Error or Inadequacy	<input type="checkbox"/> Inadequate examination or evaluation <input type="checkbox"/> Inadequate or incorrect treatment			
Injury or Harm	<input type="checkbox"/> Fall injury <input type="checkbox"/> Injury caused by another resident <input type="checkbox"/> Injury caused by equipment <input type="checkbox"/> Pressure ulcer-new or worsening			
Poor Coordination of Care	<input type="checkbox"/> Potentially preventable hospital admission <input type="checkbox"/> Unplanned hospital readmission <input type="checkbox"/> Premature transition in level of care <input type="checkbox"/> Delayed or lack of follow up from a previously identified medical issue <input type="checkbox"/> Failure or delay of a practitioner to submit a referral for a specialist or procedure/test			
Patient Rights Infringement	<input type="checkbox"/> Lack of informed consent			
Potential Fraud, Waste, Abuse	<input type="checkbox"/> Potential clinical impact from FWA report			
Serious Reportable Adverse Event	<input type="checkbox"/> Death not associated with the natural course of life or illness* <input type="checkbox"/> Severe brain or spinal damage* <input type="checkbox"/> A surgical procedure being performed on the wrong patient* <input type="checkbox"/> A surgical procedure unrelated to the patient's diagnosis or medical needs being performed on any patient* <input type="checkbox"/> Serious physical or psychological injury (i.e., suicide, abuse, neglect, exploitation) <input type="checkbox"/> Loss of function of a limb not related to natural course of an illness or condition			

Section III Occurrence Information

Date of occurrence:	Time of occurrence:	Was patient hospitalized? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Brief Description of Occurrence: <i>Provide a brief description of the incident to include the time, date, exact location, physical findings, or diagnosis.</i>	Name of hospital (if applicable):	Location of hospital (if applicable):	Hospital admission date and time (if applicable):
	Was the incident reported to a state agency? <input type="checkbox"/> Yes* <input type="checkbox"/> No *If yes, please provide the agency name:		
	Was a physician called? <input type="checkbox"/> Yes* <input type="checkbox"/> No *If yes, please provide their recommendations within the description of the occurrence.		

Section IV				QI Intake			
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QI Nurse:		Date Received:	
Referral Source:		Phone/Contact Information:	

Section V				QI Investigation			
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Date	Summary

Medical Director Review	<input type="checkbox"/> Yes <input type="checkbox"/> No	Date Forwarded to MD:	
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Section VI				Medical Director Review (If applicable)			
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Date	Summary

Section VII	Final Disposition		
Level	Recommendation	Details	Date Closed
<input type="checkbox"/> NA	Refer to the appropriate department		
<input type="checkbox"/> 1	No Further Review		
<input type="checkbox"/> 2	Track and Trend - Required		
<input type="checkbox"/> 3a	Track and Trend Optional: <input type="checkbox"/> *Education		
<input type="checkbox"/> 3b	Track and Trend Optional: <input type="checkbox"/> *Education <input type="checkbox"/> *Corrective Action Plan (CAP) <input type="checkbox"/> *Committee Review		
<input type="checkbox"/> 3c	Track and Trend Peer Review Required Optional: <input type="checkbox"/> *Education <input type="checkbox"/> *CAP <input type="checkbox"/> *Other		
* Medical Director responsible for Education, CAP and Peer Review Committee			
QI Nurse:			Date:
Medical Director Signature (Only if reviewed by MD for leveling):			Date:
<p>* Legend:</p> <p>NA – There is no medical care component to the complaint; Refer to the appropriate department to investigate if applicable</p> <p>Level 1- Acceptable medical care provided; No further review needed (RN review)</p> <p>Level 2- Acceptable medical care provided; No opportunity for improvement in medical care provided; Requires tracking (RN review)</p> <p>Level 3A - Medical care falls below standard medical practice; No adverse outcome; Requires tracking (MD); Possible education</p> <p>Level 3B - Medical care falls below standard medical practice; Resulted in additional medical/surgical intervention; Requires tracking with possible education, Peer review or CAP (MD)</p> <p>Level 3C - Medical care falls below standard medical practice; Resulted in imminent danger body/mind or death; Requires tracking and Peer review; Possible education or CAP (MD)</p>			