

Potential Quality Issue (PQI) Referral Form
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Email to: PQIReferral@curanahealth.com

Section I				General Information	
Date		Time		Health Plan	
Member name				DOB	
Member ID#				Sex (M/F)	
Provider name				Provider #	
Facility name				Facility location	
Name of person submitting the PQI				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			
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 *Florida incidents that require reporting to AHCA within 3 days of occurrence if confirmed upon Medical Director Review			
Other		<input type="checkbox"/> Quality of care concern that is not outlined above. Please specify the concern below:			

Section III		Occurrence Information	
Date of occurrence:	Time of occurrence:	Was patient hospitalized? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Details of the occurrence:	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.
	<p>Describe the potential quality concern. Include the time, date, location, physical findings, and/or diagnosis as it relates to the occurrence. If associated with an authorization, please provide the authorization number.</p>		
Signature of Person Submitting PQI:			

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

Section V		QI Investigation	
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Date	Summary
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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
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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: *Education		
<input type="checkbox"/> 3b	Track and Trend Optional: <input type="checkbox"/> *Education <input type="checkbox"/> *Correct Action (CAP) *Committee Review		
<input type="checkbox"/> 3c	Track and Trend Peer Review Required Optional: <input type="checkbox"/> *Education <input type="checkbox"/> *CAP *Other		
* Medical Director responsible for Education, CAP and Peer Committee Review			
Medical Director (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>			