

## Blair County/Central PA Health Care Quality Unit (HCQU) Referral Request Form and Outcome Documentation



### **SECTION I**

*This Central PA HCQU Referral Request should be completed when a medical need is noted in the area(s) of Training and Technical Assistance. Forward this completed form to **both** the HCQU Regional Nurse, Sandra Corrigan [slcorrigan@geisinger.edu](mailto:slcorrigan@geisinger.edu) and HCQU Director, Cheryl Callahan [ccallahan@geisinger.edu](mailto:ccallahan@geisinger.edu) and any other identified entities. Please follow the Blair County referral process guidelines.*

Date of Request	Choose calendar date
Requestor's Name/Title	Enter name and title
Name of Individual	Enter name.
Address	Enter address.
Living Situation	Choose from drop down list.
Supports Coordinator/SCO Entity	Enter name.
Provider Name	Enter name
Contact Person Name and Title	Enter name and title.
Phone Number	Enter phone number
Email	Enter email address
Best Time/Day of Week to Schedule Referral (Be specific if possible):	Be as specific as possible
Referral Request	Choose from drop down list
Choose virtual video conferencing platform:	Choose from drop down list.
Is the referral related to <b>AN HRST?</b>	Choose yes or no
Is the referral a result of <b>A CORRECTIVE ACTION PLAN?</b>	Choose yes or no
Is the referral a result of <b>A REPORTABLE INCIDENT?</b>	Choose yes or no.
If YES, select an incident category	Choose from drop down list
Reason for Referral (provide summary)	Type reason here
<b>HCQU Director Name and Referral Received Approval Date</b>	<b>Enter name and date</b>

**Section II-HCQU RN TO COMPLETE THE FOLLOWING SECTION IN BLUE- (REFERRAL OUTCOME DOCUMENTATION)**

Date Referral Completed	Choose calendar date.
Referral Completed by	Choose a nurse from drop down list
Training Title	Enter title.
Level of TA Complexity	Choose a level from drop down list.

Who received assistance? (Check all that apply)

Family	<input type="checkbox"/>	Support Coordinator	<input type="checkbox"/>	Provider Agency	<input type="checkbox"/>
ODP	<input type="checkbox"/>	Individual	<input type="checkbox"/>	AE	<input type="checkbox"/>
If Other, define			Define other.		

Type of Request (Check all that apply)

Virtual Training	<input type="checkbox"/>	Staff Training	<input type="checkbox"/>	Consumer Training	<input type="checkbox"/>
ISP Meeting(s)	<input type="checkbox"/>	Committee Meeting(s)	<input type="checkbox"/>	Provider Meeting(s)	<input type="checkbox"/>
Consumer Update Meeting(s)	<input type="checkbox"/>	Team Meeting(s)	<input type="checkbox"/>	Risk Management Meeting(s)	<input type="checkbox"/>
QA Meeting(s)	<input type="checkbox"/>	HRC	<input type="checkbox"/>	Fall Risk Review	<input type="checkbox"/>
Medication Review	<input type="checkbox"/>	Dysphagia Review	<input type="checkbox"/>	Record Review	<input type="checkbox"/>
Skin Integrity Initiative	<input type="checkbox"/>	Review Policy/Procedure	<input type="checkbox"/>	Community Outreach	<input type="checkbox"/>
Resource Sharing	<input type="checkbox"/>	HRST	<input type="checkbox"/>	Other	<input type="checkbox"/>

If Other, define	Define other.
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Please Document the Outcome of the Referral Below:

Type referral outcome here.

Supporting Documents Included	Choose yes or no.
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<b>HCQU Director Name and Referral Outcome Approval Date</b>	<b>Enter name and date.</b>
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