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| 2022 Central PA Health Care Quality Unit (HCQU)Referral Request Form and Outcome Documentation |
| SECTION I*The representative from the provider agency and/or county program will complete Section I -a referral request for HCQU services for training or technical assistance. The completed referral form will be emailed to the appropriate HCQU nurse.* |
| Date of Request | Choose calendar date  |
| Requestor’s Name/Title | Enter name and title |
| County/Joinder | Choose from drop down list. |
| 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 **AN HRST?** | Choose yes or no |
| Is the referral a result of **A CORRECTIVE ACTION PLAN?** | Choose yes or no |
| Is the referral a result of **A REPORTABLE INCIDENT?** | Choose yes or no. |
| If YES, select an incident category | Choose from drop down list  |
| Reason for Referral (provide summary) | Type reason here  |
| Referral to | Choose a nurse from drop down list |
| HCQU Director Name and Referral Received Approval Date  |  Enter name and date |
| **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) |
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| Family |[ ]  Support Coordinator |[ ]  Provider Agency |[ ]
| ODP |[ ]  Individual |[ ]  AE  |[ ]
| If Other, define | Define other. |

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| Type of Request (Check all that apply) |
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| Virtual Training |[ ]  Staff Training |[ ]  Consumer Training |[ ]
| ISP Meeting(s) |[ ]  Committee Meeting(s) |[ ]  Provider Meeting(s) |[ ]
| Consumer Update Meeting(s) |[ ]  Team Meeting(s) |[ ]  Risk Management Meeting(s) |[ ]
| QA Meeting(s) |[ ]  HRC |[ ]  Fall Risk Review |[ ]
| Medication Review |[ ]  Dysphagia Review |[ ]  Record Review |[ ]
| Skin Integrity Initiative |[ ]  Review Policy/Procedure |[ ]  Community Outreach |[ ]
| Resource Sharing |[ ]  HRST  |[ ]  Other |[ ]

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| If Other, define  | Define other. |
| Please Document the Outcome of the Referral Below: |
| Type referral outcome here. |
| Supporting Documents Included | Choose yes or no. |
| **HCQU Director Name and Referral Outcome Approval Date**  | Enter name and date. |