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| 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*](mailto:%20slcorrigan@geisinger.edu)*and HCQU Director,* [*Cheryl Callahan*](mailto:clcallahan@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. |
| Individual’s Date of Birth | Click or tap to enter a date. |
| HRST HCL Score (if applicable) | Enter number. |
| 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/Weekday 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 |
| **A CORRECTIVE ACTION PLAN?** | Choose yes or no |
| **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 |
| 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) | |
| |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | | Family |  | Support Coordinator |  | Provider Agency |  | | ODP |  | Individual |  | AE |  | | If Other, define | | | Define other. | | | | |
| Type of Request (Check all that apply) | |
| |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | | 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 |  | | |
| 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. |