PARTNERSHIP HEALTHPLAN of CALIFORNIA

Potential Quality Issue (PQI) Referral Form

Patient Name:	Last Name:		First Name:
Gender:	☐Male	☐ Female	Date of Birth:
Member ID#:			Age:
Reported By:	Last Name:		First Name:
Job Title:			☐ Internal:
Phone #:			☐External:
Referral Type:	☐ Medical ☐Dental ☐ Vision ☐Behavioral ☐Ancillary ☐ Pharmacy		

Date PQI was first identified:

Date of PQI referral submission to Quality Improvement (QI) Department: Provider of Concern:

Provider: ☐ Contracted ☐ Non-Contracted If contracted, please indicate the facility/provider ID #:

Description of Events:

(Please describe what happened and why the case is being referred as a PQI.)

PLEASE MARK APPLICABLE INDICATORS THAT DESCRIBE THE CONCERN (MAX 2)		
☐Admit within 3 days of ER Services	☐Assessment/Treatment/Diagnosis	☐Continuity of Care
☐Mental Health	☐Pharmacy	☐Readmission/UM
☐Safety	☐Surgical Services	☐Maternal Child Services
☐Unexpected Death	☐Unsure	☐Other