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)

☐ Access/Availability	☐ Admit within 3 days of ER	☐ Assessment/Treatment/Diagnosis
☐ Communications/Conduct	☐ Continuity of Care	☐ Mental Health
☐ Pharmacy/UM Authorizations	☐ Readmission	☐ Safety
☐ Surgical Services	☐ Other:	☐ Unexpected Death
☐ Unsure		