Quality of Care Referral

All information provided in these appended materials is compiled at the direction of the CountyCare Quality Department and is privileged and confidential to be used solely in the course of internal quality control and for the purpose of reducing morbidity and mortality and assessing or improving the quality of care provided to our members. This information is protected under the Illinois Medical Studies Act.

1. Referral Source (UM/Concurrent Review, Case Management, Provider)

Date:	Organization/Department:
Name & Title:	Telephone number/extension:
Supervisor Name & Title (if referent is not a supervisor):	Supervisor telephone number/extension:

2. Case File Information

Member name	
Member DOB	
Medicaid RIN	
Medical Home/PCP	
Provider/Facility/Practitioner	
Provider address/phone number	

3. Type of Issue (Check all that apply)

Adverse Medical Event	Adverse Surgical Event	Allergic/Adverse Drug Reaction	Death (includes fetal death >24 wks. gestation)
Readmission within 30 days	Infection	Suicide	Other ______________________

Why do you feel this is a quality of care concern?

4. Summary of Issue with Any Actions Taken (including addressing care coordination needs)

PLEASE RETURN THIS FORM VIA SECURE EMAIL TO CountyCareQualityofCare@CookCountyhhs.org