



Northeastern PA Health Care Quality Unit Referral Request

Process for Referral to the HCQU

1. The representative from the provider agency, county program, family or other support services will complete a referral request for HCQU services.
2. The Supports Coordinator or HCQU liaison will be informed of a consumer-specific referral either by the requestor or HCQU nurse.
3. The referral form will be given to the HCQU nurse or faxed to the HCQU at (570) 558-3209.

County/Joinder: _____ **Supports Coordinator:** _____

Supports Coordinator Phone: _____ **Supports Coordinator Fax :** _____

Date of referral to HCQU: _____

Provider Name: _____ **Contact person:** _____

Contact's phone number: _____ **Fax number:** _____

Individual's Name (if applicable): _____

Primary Diagnosis: _____ **Secondary Diagnosis:** _____

Address: _____

Phone number: _____

REASON FOR REFERRAL:

Completed by: _____ **Date/Time:** _____

The following information will be completed by HCQU

Date Received by HCQU: _____ **Staff assigned:** _____

HCQU Director: _____ **Date:** _____

Outcome: (Check all that apply)

- | | | |
|---|---|---|
| <input type="checkbox"/> Video | <input type="checkbox"/> Technical Assistance | <input type="checkbox"/> Other (explanation needed) |
| <input type="checkbox"/> Information/resources | <input type="checkbox"/> Meeting Attendance | |
| <input type="checkbox"/> Assistance with policy/procedure | <input type="checkbox"/> Psychiatric Evaluation | |
| <input type="checkbox"/> Consumer Assessment | <input type="checkbox"/> Training | |

Further Explanation (i.e., complexity/time spent on technical assistance):

Staff signature: _____ **Date closed:** _____