Eastern 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 (610)435-9398.

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)

- ☐ Video
- ☐ Information/resources
- ☐ Assistance with policy/procedure
- ☐ Consumer Assessment
- ☐ Technical Assistance
- ☐ Meeting Attendance
- ☐ Psychiatric Evaluation
- ☐ Training
- ☐ Other (explanation needed): _____

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

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