



**OKLAHOMA TRAUMA SYSTEM QUALITY IMPROVEMENT PROCESS
REFERRAL FORM**

Please complete this form and attach related records.

Reporting individual contact information		<input type="checkbox"/> I wish to remain anonymous
<i>Date</i>		
<i>Full name and title</i>		
<i>Organization</i>		
<i>Telephone number</i>		
<i>Email address</i>		
Patient information for review		
<i>Date of incident</i>		
<i>Name of patient</i>		
<i>Patient date of birth</i>		
<i>Your medical record#</i>		
<i>Name of any other involved agency/facility</i>		
Reason for requesting review: (Check all applicable boxes and include a brief narrative)		
<input type="checkbox"/> <i>Good Job!</i>		
<input type="checkbox"/> <i>Incorrect application of the Trauma Triage, and Transport Algorithm</i>		
<input type="checkbox"/> <i>Deviation from Regional Trauma Plan</i>		
<input type="checkbox"/> <i>Delay in care</i>		
<input type="checkbox"/> <i>Communication problems</i>		
<input type="checkbox"/> <i>Refusal</i>		
<input type="checkbox"/> <i>Other(please specify)</i>		
Additional information:		

Mail, fax, or email to:
 Oklahoma State Department of Health
 Emergency Systems- Attn:Trauma CQI
 123 Robert S Kerr Ste.1702 Oklahoma City, OK 73102
 Phone:(405) 426-8480 Fax: (405) 900-7561
 Email: CQI@health.ok.gov