## OKLAHOMA HEALTH CARE AUTHORITY QUALITY REFERRAL FORM

For submission to the Community Living Services - Quality Assurance Unit

Case Number (assig	ned by QAU):				
Date of Referral to					
Referred to QAU by					
Program:					
Recipient/Facility:					
Recipient/Provider	ID:				
				T	
Referral Source:		Recipient	Specify:		
		Provider	Specify:		
		Internal Source	Specify:		
		External Source	Specify:		
Tier 1 : Quality of C	Care				
Tier 2: Cultural Change					
Tier 3: Member Satisfaction					
Summary of Issue(s)	)•				
NAME:		Ε	DATE:		
DATE REVIEWED:			SUPERVISOR SIGNATURE:		

Focus on Excellence

**ONLY**