PATIENT QUALITY OF CARE AND/OR QUALITY OF SERVICE REVIEW FORM

Section I

Date of Incident: Time of Incident: Health Center:

Location of Incident:

Patient Name (if applicable): MR#: DOB:

Practitioner/Staff involved:

Please provide a brief description of incident or issue, including people/equipment involved and any treatment provided (if indicated):

Primary issue identified: Secondary Issue Identified:

Your Name: Date: Health Center:

After completing Section I (above), send form to the appropriate Supervisor/Manager. IF you are unclear who that is, send to: qualityreporting@vmgma.com

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Section II - To be completed by Supervisor/Manager(s)

Provide reference to pertinent documentation in EMR, attach copies of all relevant and supporting documentation that is not include in EMR

Incident/Issue Review & Findings:

Initial Review Completed by: Date:

Stop Here: Send review to additional Manager/Supervisor if appropriate

Additional comments/investigation (if needed):

Section III – To be completed by Supervisor/Manager

Determination 1: Disposition 1:

Determination 2: Disposition 2:

Review Completed by: Date:

Stop Here: Email completed for to: qualityreporting@vmgma.com

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Section III – Completed by Quality Assurance

Resolution and/or Further Action needed:

No further action	Patient reimbursed
Copy sent to Human Resources	Letter mailed to patient
Copy sent to Risk Manager	Peer Review

Comments/Peer Review Findings:

QA Reviewer's Signature Date:

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