

Oklahoma Trauma System Performance Improvement Process

Referral Intake Form

TReC # _____

Please complete this form and attach related records.

| | |
|---|--|
| Individual Reporting: Contact Information | |
| <i>Date</i> | |
| <i>Full Name/Title</i> | |
| <i>Organizational Affiliation</i> | |
| <i>Telephone #</i> | |
| <i>Address</i> | |
| Brief Description of Information for Review | |
| <i>Date of Incident</i> | |
| <i>Name of Patient</i> | |
| <i>Your Medical Record #</i> | |
| <i>Name of other agency / facility involved</i> | |
| <p>Why are you requesting a review? <i>Check applicable boxes and include a brief narrative of the event.</i></p> <p>Pre-Hospital Care</p> <p>ED Care</p> <p>Operative Care</p> <p>Post-op/Post-ED Care</p> <p>Delay</p> <p>Communication Problem</p> <p>Transfer</p> <p>TReC</p> | |

Please complete this form and attach ED and related Medical Records

Mail or fax to:

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