



Oklahoma State Department of Health
Creating a State of Health

OKLAHOMA TRAUMA SYSTEM PERFORMANCE IMPROVEMENT PROCESS REFERRAL FORM

TReC # _____

Please complete this form and attach related records.

Reporting individual – Contact information:	
<i>Date</i>	
<i>Full Name/Title</i>	
<i>Organizational Affiliation</i>	
<i>Telephone#</i>	
<i>Address</i>	
<i>Email address</i>	
Brief description of 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>Pre-Hospital Care</i>	<input type="checkbox"/> <i>Delay to Definitive Care</i>
<input type="checkbox"/> <i>ED Care</i>	<input type="checkbox"/> <i>Communication Problem</i>
<input type="checkbox"/> <i>Operative Care</i>	<input type="checkbox"/> <i>Interfacility Transfer</i>
<input type="checkbox"/> <i>Post-Op / Post-ED Care</i>	<input type="checkbox"/> <i>EMResource / TReC</i>
Narrative:	

Please complete this form and attach any related documentation (medical records, run reports, etc).

Mail or fax to:

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