OKLAHOMA HEALTH CARE AUTHORITY

QUALITY REFERRAL FORM

For submission to the

Community Living Services - Quality Assurance Unit

Case Number (assigned by QAU):	
Date of Referral to QAU:	
Referred to QAU by:	
Program:	

Recipient/Facility:	
Recipient/Provider ID:	

Referral Source:	☐	**Recipient**	**Specify:**	
	☐	**Provider**	**Specify:**	
	☐	**Internal Source**	**Specify:**	
	☐	**External Source**	**Specify:**	

Focus on Excellence ONLY

Tier 1 : Quality of Care		
Tier 2: Cultural Change		
Tier 3: Member Satisfaction		

Summary of Issue(s):

NAME:_____ **DATE:** _____

DATE REVIEWED: _____ **SUPERVISOR SIGNATURE:** _____