

Quality Log # _____

ConnextCare
Quality Improvement Identification Form

Patient's Name: _____ DOB: _____

Other Person(s) Involved: _____

Date Incident Occurred: _____ Location Incident Occurred: _____

TO BE COMPLETED BY PATIENT IF POSSIBLE

Issue of Concern: _____

Section Completed By: _____ Date completed: _____

Please return to the front desk so that your
concerns may be brought to the site supervisor

If corresponding by mail, please send to: ConnextCare,
attn: Clinical Administrative Coordinator, 61 Delano St,
Pulaski, NY 13412

TO BE COMPLETED BY SITE SUPERVISOR IF APPLICABLE

Section completed by: _____ Date completed: _____

Action Taken: _____

Plans for future prevention:

Issue resolved? Yes → No → Notified by: Phone Letter

No → Issue requires further attention from Quality Department

Urgent? Yes No

Say hello to healthy

ConnexCare - Quality Improvement Assessment Form
ATTACH TO COMPLETED QUALITY IMPROVEMENT IDENTIFICATION FORM

Forwarded to: _____ MED / NSG / OP (CC to CQO)

FORWARDEE RESPONSE(S)

Recommended Follow Up/Action Taken:

source of any error that you believe occurred: _____

Was Standard of Care met: Yes No

Was Standard of Care met with need for improvement: Yes

Identify what improvement is needed: _____

FOR USE BY QUALITY PROGRAM SPECIALIST

Date received: _____ Date returned by CQO/ final outcome logged: _____

Date logged: _____ Quality Log # _____

FOR USE BY CHIEF QUALITY OFFICER

Further follow-up Action: _____ Date of follow-up _____

Plans for Future Prevention: _____

Letter Sent

Error Type(s): _____ Severity of harm: 0 1 2 3 4 5

Date Returned to QPS: _____

Date Reviewed by Quality Committee: _____

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