ConnextCare™
A Community of Care

61 Delano Street, Pulaski, New York 13142-1400
Phone: (315) 298-6569 Fax: (315) 298-7488 TDD: 711
www.connextcare.org

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:_____
ActionTaken:_____
_____
_____
_____
_____ _____
Plans for future prevention:
_____
_____

Issue resolved? □ Yes → **Notified by:** □ Phone □ Letter
□ No → Issue requires further attention from Quality Department
Urgent? □ Yes □ No

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ConnextCare - 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: _____