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

Say hello to healthy

ConnextCare™
A Community of Care

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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: ___________________