South Central PA Health Care Quality Unit
Referral Request

Process for Referral to the HCQU:

1. Complete each section, as appropriate.
2. Forward to the County Administrative Entity (AE) for approval, if needed.
3. **Email the completed referral form to HCQU Director Katie Freeman at kf1@theadvocacyalliance.org**

Supports Coordinator:
Name: ________________________________
Phone: ________________________________
Email: _________________________________

Provider Information:
County/Joinder: _________________________
Provider Name: _________________________

Contact Person:
Name: _________________________________
Phone: _________________________________
Email: _________________________________
Relationship to Individual: ________________

Supported Individual (*if applicable*):
Name: _________________________________
Age: __________________________________
Diagnoses (*related to this referral*):
____
____

Appointment Preference:
In-Person______ Virtual_____ No preference_____

REASON FOR REFERRAL *(select all that apply):*
Consumer Data Collection (CDC) ☐ Training ☐ Pharmacy Review ☐ Psychiatric Review☐
Fall Risk Data Collection ☐ Bio-Graphical Timeline☐

Additional information about this request:

Completed by: ____ **Date/Time:** ____________________

County AE signature: ____ **Date:** ____________________

The following information will be completed by HCQU:

Date Received by HCQU: ____________________ **HCQU Director:** ____________________________

Staff Assigned: ____________________ **Date:** ____________________