



Phone: (717) 835-2270

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South Central Health Care Quality Unit Referral Request

Process for Referral to the HCQU:

1. The representative from the provider agency, county program, family or other support services will complete a referral request for HCQU services.
2. The Supports Coordinator or HCQU liaison will be informed of the referral by the requestor or HCQU nurse.
3. **Email the completed referral form to HCQU Director Katie Freeman 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: _____

Appointment Preference:

In-Person _____ Virtual _____ No preference _____

REASON FOR REFERRAL:

- Consumer Data Collection (CDC-Medical and Behavioral Assessment) Training
 Pharmacy Review Psychiatric Review Fall Risk Data Collection Bio-Graphical Timeline

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: _____