Phone: (717)835-2270

Fax: (717)835-2299

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: _____

Contact Person:
Name: _____
Phone: _____
Email: _____
Relationship to Individual: _____

Provider Information:
County/Joinder: _____
Provider Name: _____
Address for the appointment: _____
_____

Supported Individual (*if applicable*):
Name: _____
Age: _____
Diagnoses: _____
_____

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: _____

Scheduled Date and Time:_____ SC Notified: Yes____ NO____