



OKLAHOMA TRAUMA SYSTEM QUALITY IMPROVEMENT PROCESS
REFERRAL FORM

Please complete this form and attach related records.

Reporting individual contact information		☐ I wish to remain anonymous
Date		
Full name and title		
Organization		
Telephone number		
Email address		
Patient information for review		
Date of incident		
Name of patient		
Patient date of birth		
Your medical record#		
Name of any other involved agency/facility		
Reason for requesting review: (Check all applicable boxes and include a brief narrative)		
☐ Good Job!		
☐ Incorrect application of the Trauma Triage, and Transport Algorithm		
☐ Deviation from Regional Trauma Plan		
☐ Delay in care		
☐ Communication problems		
☐ Refusal		
☐ Other(please specify)		
Additional information:		

Mail, fax, or email to:
Oklahoma State Department of Health
Emergency Systems- Attn:Trauma CQI
123 Robert S Kerr Ste.1702 Oklahoma City, OK 73102
Phone:(405) 426-8480 Fax: (405) 900-7561
Email: CQI@health.ok.gov