Date: ___________ Time: ______ Name of Person/Employee Calling Problem: ________________

Patient Name (optional) ________________________________________________________________

Patient Medical Record #(optional) __________ Phone# ____________________________

Nature of OFI (Include how often/long this has occurred and previous actions taken to address/solve problem): ________________________________________________________________

______________________________________________________________________________

______________________________________________________________________________

______________________________________________________________________________

______________________________________________________________________________

Reason for Referral:

☐ Opportunity for Improvement ☐ Solve a known problem

☐ Evaluate Stability of Process ☐ Other ______________________________

Process/Outcome is being measured because it is:

☐ High Risk ☐ High Volume ☐ Problem Prone ☐ Other ______________________________

Does the problem cross departmental line? ☐ Yes ☐ No

List all affected departments: ______________________________________________________

______________________________________________________________________________

______________________________________________________________________________
Indicate all priorities impacted by this process/problem:

- [ ] Life Threatening
- [ ] Safety/Patient Safety
- [ ] Decreased Customer Satisfaction
- [ ] Public Relations
- [ ] Increased Cost
- [ ] Potential Liability
- [ ] Ethical Impact
- [ ] Impacts Regulatory Compliance
- [ ] Potential for Complications

Function(s) to which Opportunity/Problem relates:

- [ ] Right & Ethics
- [ ] Leadership
- [ ] Information Management
- [ ] Improving Performances
- [ ] Provision of Care
- [ ] Human Resources
- [ ] Environment of Care
- [ ] Nursing
- [ ] Medication Management
- [ ] Infection Control
- [ ] Medical Staff

Dimension of performance to which opportunity/problem relates:

- [ ] Respect & Caring
- [ ] Availability
- [ ] Continuity
- [ ] Cost effectiveness
- [ ] Efficacy
- [ ] Timeliness
- [ ] Safety/Patient Safety
- [ ] Appropriateness
- [ ] Effectiveness
- [ ] Efficiency

Any additional comments or explanation: __________________________________________
________________________________________

NOTE: Prioritization scoring will be completed by the Chief Quality Officer and/or the Performance Improvement Council using the approved Prioritization Form, with results to be reported to and confirmed by the Quality Performance Improvement Council

ONLY the Quality Performance Improvement Council, CEO, or Chief Quality Officer may charter Quality Improvement Teams.

Quality Performance Improvement Council designee to complete this section
PRIORITIZATION SCORE: _______________
RECOMMENDED ACTION:

- [ ] Trend Data
- [ ] Referred to Department Manager
- [ ] Referred to Administration
- [ ] Quality Improvement Team
- [ ] Other: ________________________________

Action Taken: ______________________________________
________________________________________
________________________________________

Date/Time OFI Answered: __________________________
Handled by: ________________________________