

RISK MANAGEMENT REFERRAL

CONFIDENTIAL

Patient information

Patient name: _____

DOB: _____ SSN: _____

MRN: _____ Phone: _____

Address: _____

Source

Date of report: _____ Location: _____

Reporting provider/staff member: _____

Additional treating providers: _____

Problem Description

Non-compliance: _____

Medication: _____

Legal concern: _____

Other: _____

Disposition (check all that apply):

- Suggest risk manager contact patient as directed:

- Suggest termination of provider/patient relationship

- Record/monitor only. No follow-up requested at this time

- Other _____

Follow-up Action _____
