RETRAC PERFORMANCE IMPROVEMENT REPORTING FORM

Referral From Date:	**Referral To Date:**
☐ENTITY_____ ☐EMS BUREAU/TRAUMA PROGRAM ☐HOSPITAL_____ ☐MEDICAL DIRECTION (EMS) ☐RETRAC _____ ☐TASSC ☐TNCF ☐OTHER_____	☐ENTITY_____ ☐EMS BUREAU/TRAUMA PROGRAM ☐HOSPITAL_____ ☐MEDICAL DIRECTION (EMS) ☐RETRAC _____ ☐TASSC ☐TNCF ☐OTHER_____

Contact Person:		**Contact Person:**	
E-Mail:		**E-Mail:**	
Mailing Address:		**Mailing Address:**	

TYPE OF ISSUE

☐**System related** ☐**Patient related** ☐**Provider related** ☐**To be determined**

SPECIFIC PATIENT INFORMATION ☐**NOT APPLICABLE**		
Age:	**Gender: M/F**	**Trauma Registry #:**
Mechanism of injury:		
Patient Outcome		

DISCUSSION OF COMPLICATION, PROBLEM OR COMPLAINT:

__No negative outcome __Minor negative outcome __Significant system performance error __Major deviation from desired system performance __Unable to determine	__Standard of care met ☐ Yes ☐ No __Guidelines followed __Minor deviation from guidelines __Significant deviation from guidelines __Major deviation from guidelines __Unable to determine

Loop Closure plan/discussion:_____

_____

_____

_____

Confidential Peer Review

PURSUANT TO SECTION 41-9-5, NMSA Review Organization Immunity Act

ACTION/PLAN: Does any action need to be taken on findings of this indicator review? If yes, describe the plan of action that must be taken to ensure loop closure.

If Referral needed:

Date	REFERRAL TO:	
	☐Entity _____ ☐EMS Bureau/Trauma Program ☐Hospital _____ ☐ Medical Direction Committee	☐ReTrAC _____ ☐TASSC ☐TNCF ☐TPIC ☐Other _____

Contact Person:	
E-Mail:	
Mailing Address:	

FOLLOW UP:				
Expected Completion Date?				
Person responsible for follow up:				
TO BE COMPLETED BY REFERRAL TO ENTITY				
Summary of Follow Up:				
Completed by:			Date:	
☐No Action Needed				
☐Review with Hospital or EMS Provider				
☐Track and Trend				
☐Education ☐Individual ☐ Entity				
☐ReTrAC guideline Review				
☐Hospital EMS Action Plan Requested				
☐Refer to TPIC				
☐Refer to Workgroup What workgroup:				
☐Other				

Date	Additional referral needed ☐YES ☐NO	
	☐Entity _____ ☐EMS Bureau/Trauma Program ☐Hospital ☐Medical Direction Committee	☐ReTrAC _____ ☐TASSC ☐TNCF ☐TPIC ☐Other _____