KAISER PERMANENTE®

QUALITY/PEER REVIEW REFERRAL

To be completed by person requesting review:

* denotes required field

Patient Name*		**HRN* :**		**DOB**		**Age:**	

Inpatient Facility*:		**Hospital MRN:**	

Admission Date*:		**Date of Discharge*:**	

For Readmissions:

Initial or Previous Medical Facility:	

Date of Admission:		**Date of**	

Reason for Referral *

Referral	

Confidential proceedings and records of a Peer Review Organization and Medical Review Committee are protected by: O.C.G.A., Section 31-7-131 thru 31-7-143.

Description of Issue*	

Name*:		**Phone Number*:**	

Date of referral*:		**Email address:**	

Peer Review FAX: **404.949.5341**

EMAIL TO: Peerreview-Dept-Mail
Global look up: MAILBOX , peerreview dept

Print Form

PRF 10.21.09