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

PRF 10.21.09