## RETRAC PERFORMANCE IMPROVEMENT REPORTING FORM

<table>
<thead>
<tr>
<th>Referral From Date:</th>
<th>Referral To Date:</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐ ENTITY</td>
<td>ENTITY</td>
</tr>
<tr>
<td>☐ EMS BUREAU/TRAUMA PROGRAM</td>
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<tr>
<td>☐ HOSPITAL</td>
<td>☐ HOSPITAL</td>
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<tr>
<td>☐ MEDICAL DIRECTION (EMS)</td>
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<td>☐ RETRAC</td>
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</tr>
<tr>
<td>☐ TASSC</td>
<td>☐ TASSC</td>
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<tr>
<td>☐ TNCF</td>
<td>☐ TNCF</td>
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<tr>
<td>☐ OTHER</td>
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### Contact Person:

- **E-Mail:**
- **Mailing Address:**

### Type of Issue

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

### Specific Patient Information

- ☐ NOT APPLICABLE

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<tr>
<th>Age:</th>
<th>Gender: M/F</th>
<th>Trauma Registry #:</th>
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- **Mechanism of injury:**
- **Patient Outcome**

### Discussion of Complication, Problem or Complaint:

Loop Closure

plan/discussion:

- No negative outcome
- Minor negative outcome
- Significant system performance error
- Major deviation from desired system performance
- Unable to determine

- Standard of care met
- Guidelines followed
- Minor deviation from guidelines
- Significant deviation from guidelines
- Major deviation from guidelines
- Unable to determine

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.

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If Referral needed:

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- [ ] Entity
- [ ] EMS Bureau/Trauma Program
- [ ] Hospital
- [ ] Medical Direction Committee
- [ ] ReTrAC
- [ ] TASSC
- [ ] TNCF
- [ ] TPIC
- [ ] Other

Contact Person:  
E-Mail:  
Mailing Address:

**FOLLOW UP:**

<table>
<thead>
<tr>
<th>Expected Completion Date?</th>
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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  
- [ ] Other

Date | Additional referral needed  
|-----|--------------------------|
|     | [ ] YES  
|     | [ ] NO  

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