# Quality of Care Outreach Letter

Date: _____ Provider: _____

Patient: _____ Office Location: _____

Date of Birth: _____

**Dear Provider,**

Thank you for allowing us to provide care for your patient on behalf of Triad HealthCare Network. We would like to inform you on a recent interaction we had with your patient, and the table below summarizes outcomes and his/her requests. Please let us know if you have any questions. We always appreciate delivering high quality of care for our patients.

| | **THN mailed a kit to patient upon request** | **THN scheduled procedure upon request** | **Attached the records for your review** | **Patient reported outcomes collected for your review** | **Patient requests Provider to schedule** | **Patient Requests a kit mailed Provider to fax an order to THN (336-663-5372)** |
|---|---|---|---|---|---|---|
| **Annual Wellness Visit (AWV)** | | | | | ☐ AWV | |
| **Breast Cancer Screening** | | ☐ Mammogram | ☐ | Date: _____<br>Test: _____<br>Result:_____ | ☐ Mammogram | |
| **Colorectal Cancer Screening** | ☐ iFOBT | | ☐ | Date: _____<br>Test: _____<br>Result:_____ | ☐ Colonoscopy<br>☐ Cologuard<br>☐ iFOBT<br>Other: _____ | |
| **Diabetes Care: A1c** | | | ☐ | Date: _____<br>Test: _____<br>Result:_____ | ☐ HbA1c | ☐ HbA1c |
| **Diabetes Care: Eye Exam** | | | ☐ | Date: _____<br>Test: _____<br>Result: _____<br>☐ Ophthalmologist<br>☐ Optometrist | ☐ Diabetes eye exam | |
| **Diabetes Care: Nephropathy Screening** | | | ☐ | Date: _____<br>Test: _____<br>Result:_____ | ☐ Microalbumin or urine test | ☐ Microalbumin |
| **Flu Vaccine** | | | ☐ | | ☐ | |
| **Fall Screening** | | | ☐ | | ☐ | |
| **Tobacco Screening** | | | ☐ | | ☐ Cessation | |
| **Osteoporosis Management in Women who had a Fracture** | | | ☐ | | ☐ Dexa Scan<br>☐ Osteoporosis Medication | |
| **Medication Reconciliation Post-Discharge** | | | ☐ | | ☐ Hospital Follow-up visit | |

Sincerely, _____

Contact Phone number: _____