

NURSING RESOURCE COMMITTEE REFERRAL

Date, Time & Initials

(for office use only)

This form is to be used if a Registered Nurse has a good faith belief s/he has been given an assignment or instruction that compromises patient care or patient safety. The Registered Nurse should first report the concern to the direct supervisor as soon as practically possible stating the specific nature of the objection. In addition, the Registered Nurse will complete this form prior to, or at the conclusion of, the shift during which the assignment/instruction was made and bring it to the ORC/Nursing Administration (Levy 2 East) where it will be date and time stamped for delivery to the Director of Nursing Operations.

Today's Date: _____

Employee Name(print): _____

Employee Position/Title: _____

Employee Phone Number: _____

Directive or Situation

Date: _____ Time/Shift: _____ Unit: _____

Nature of Concern:

- | | |
|---|--|
| <input type="checkbox"/> Training or experience level | <input type="checkbox"/> Isolation Precautions |
| <input type="checkbox"/> Staffing | <input type="checkbox"/> Acuity |
| <input type="checkbox"/> Equipment/supplies | <input type="checkbox"/> Hours Worked |
| <input type="checkbox"/> Others | |

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Summary of What Occurred: (who, what, where; list names of witnesses; document specifics, factual comments only, including your reason for concern.)

Additional Information:

Unit Census: _____

Patient Care Staffing Count:

	Regular Full/Part Time	Per Diem	Reassigned (include unit reassigned from)	Agency/Traveler	Number of Call Outs
RN					
PCA					

Was there a Health Unit Coordinator working? ☐ Yes ☐ No

I attest that the information detailed above is true and accurate.

Signature of RN Completing Form

2/1/2018

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Comments from Nurse Manager of the unit:

Signature of Nurse Manager _____

Date _____