

**MA Coalition for the Prevention of Medical Errors**  
**Communicating Critical Test Results Team**

**Organization:** \_\_\_\_\_

**Team Members:**

Identify a multidisciplinary team for planning and implementing changes

1. Executive sponsor \_\_\_\_\_
2. Physician co-leader \_\_\_\_\_
3. Nursing co-leader \_\_\_\_\_
4. Staff nurse \_\_\_\_\_
5. Laboratory representative \_\_\_\_\_
6. Cardiology representative \_\_\_\_\_
7. Radiology representative \_\_\_\_\_
8. Patient safety/QI representative \_\_\_\_\_
9. Staff education representative \_\_\_\_\_
10. Communication center representative \_\_\_\_\_
11. Communication center representative \_\_\_\_\_
12. IT representative \_\_\_\_\_
13. Other \_\_\_\_\_

Representatives from the following groups, if not already included in the list above, have been found to be quite helpful in promoting the adoption of these patient safety practices:

- Chief Medical Resident (with responsibility to report back to other residents)
- Hospitalists