Cruz Clinic/Integrative Psychology - Coordination of Care

FOR YOUR INFORMATION ONLY - NOT A REQUEST FOR MEDICAL RECORDS

Patient Name: _____ Date of birth: _____

Behavioral Health Provider/Primary Care Physician Communication Form

Patient Consent to Exchange Information (to be completed by patient)

I, _____, **authorize / do not authorize** (CIRCLE ONE)
Cruz Clinic to send this coordination of care form to my primary care physician.

Primary Care Doctor Name _____
Primary Care Doctor Address _____
Primary Care Doctor Phone _____
Primary Care Doctor FAX _____

_____Patients please initial if you prefer no coordination of care and received "Be Your Own Health Manager" information sheet.

To exchange information regarding my mental health/substance abuse treatment and medical healthcare coverage for coordination of care purposes as may be necessary for the administration and provision of my health care coverage. The information exchanged may include information on mental health care or substance care and or treatment such as diagnosis and treatment plan. I understand that this authorization shall remain in effect for the course of this treatment. I understand that I may revoke this authorization at any time by written notice to the above behavioral health provider. I also understand that it is my responsibility to notify my behavioral health provider if I choose to change my Primary Care Physician. I also understand that most health care insurance (under the new health care act) require coordination of care with your PCP prior to paying for services rendered.

_____ _____
Patient Signature Date

_____ _____
Signature of Parent/ Guardian (If patient is a minor) Date

_____ _____
Signature of Witness Date

Provider Information (To be completed by Behavioral Health Provider)

(Provider Name) _____ at Cruz Clinic
17177 N. Laurel Park Drive, Ste 131, Livonia, MI. 48152 Phone 734-462-3210 Fax 734-462-1024
DSM V Diagnosis code & name:_____

Symptoms:_____
Treatment Type _____ Frequency _____ Length of TX_____
Medication (s) Prescribed: _____
___ screening tools attached (check here)
___ psychosocial assessment attached (check here)
Comments: _____

For Urgent or emergency situation, please call the primary care physicians In addition to sending form

Conclusion of mental health/ Substance treatment
_____ Date of last session _____ treatment completed? Yes _____ No_____
_____ Notification of prescription or change in medications (see comments)
_____Summary of care attached (check here)
_____ Comments: _____

_____ _____ _____
Provider's Signature Credentials (MD, PA ,NP, or Therapist) Date

A COPY OF THIS FORM MUST BE SENT TO THE PRIMARY CARE PHYSICAIN, RETAINING THE ORGINAL IN THE PATIENT CHART. IF THE FORM IS SENT BY FAX, ATTACH CONFIRMATIONN THAT THE FAX WAS SENT.
DATE SENT _____ SENT BY INTIALS_____ FAX OR MAIL

Please File in Patient's Chart