



# BEHAVIORAL/PHYSICAL HEALTH COORDINATION FORM

		Date (month, day, year)	
Name of member		Date of birth (month, day, year)	
Health care provider		Behavioral health provider	
Address (number and street)		Address (number and street)	
City, state, ZIP code		City, state, ZIP code	
Telephone number ( )	Fax number ( )	Telephone number ( )	Fax number ( )

This form was filled out by

The sharing of prescribed medication and treatment recommendations between this patient's physical healthcare provider and behavioral healthcare provider are essential for safe, effective coordination of care. Please complete the applicable section of this form and forward to the appropriate health care professional.

**More information: [www.mhsindiana.com](http://www.mhsindiana.com) or [www.cenpatico.com](http://www.cenpatico.com)**

## PATIENT CONSENT

Please check if you **DO NOT** want the following protected health information released: ☐ Behavioral Health ☐ Substance Abuse ☐ HIV/AIDS

This authorization will expire on \_\_\_\_\_. I authorize the use and/or disclosure of my protected health information as described above. I understand this authorization for release of protected health information is made to confirm my wishes. I understand that I may revoke this authorization at any time by giving written notice to the person or organization that is authorized above to release information. My health care provided by \_\_\_\_\_ will not be affected if I do not sign this form. This information disclosed by this release may be re-disclosed

Name of provider

Signature of member

by the recipient and may no longer be protected.

Signature of member

☐ **Member declined to participate**

## PHYSICAL HEALTH CARE PROFESSIONAL TO COMPLETE THE FOLLOWING

☐ Medication log attached

MEDICATION	DATE STARTED	PRESCRIBED DOSAGE	Allergies to medications:
1.			
2.			Current diagnosis:
3.			
4.			Comments:
5.			
6.			

## BEHAVIORAL HEALTH PROVIDER TO COMPLETE THE FOLLOWING

☐ Medication log attached

MEDICATION	DATE STARTED	PRESCRIBED DOSAGE	Allergies to medications:
1.			
2.			Current diagnosis:
3.			
4.			Comments:
5.			
6.			

Please provide the following information regarding (Member name)

2. Is another appointment required? ☐ Yes ☐ No If yes, date and time scheduled ☐ AM ☐ PM

1. Results of appointment, including any prescriptions ordered (attach forms as necessary)

3. Are there any special instructions for this member to follow? (please describe)