Coordination of Healthcare Exchange of Information

Sharing medication and treatment information between physical and behavioral health providers is essential for safe and effective care coordination. Please complete applicable sections of this document to share information regarding your CareSource patient’s care and include signed consent for releasing information, as appropriate.

Patient Information	
Member Name:	Member ID Number:
Date Information Completed:	Member Date of Birth:
Name of person completing information (print):	
Title of person completing information:	
Signature of person completing information:	
Member Consent: ‘ 0HPEHU KDV VLJQHG DQ DXWKRUL]HG IRUP DOORZ *must be marked if H[FKDQJH SHUV info rmation provided ‘ 0HPEHU was seen but refuses to give consent for sharing information	

Provider Information	
Primary Care Provider:	Behavioral Health Provider:
Address:	Address:
City State ZIP code	City State ZIP code
Telephone:) D [( ) -	Telephone:) D [( ) -

Member Clinical Information

*Remember to monitor/order appropriate preventative screenings (provide GA link to CPGs)

Reason(s) for Referral/Change in Treatment

Member Active Diagnoses (or attach list)		

Member Medications You Prescribe (or attach list)		
Medication Name	Dose	How Taken

Recent Labs (or attach list)		

0RVW 5HFHQW +RVSLWDOL]DWLRQV 3DVW <HDU ‘ FKHF	
Hospital	Reason for admission

‘ 0RVW RI WKH WLPH ‘ +DOI RI WKH WLPH ‘ /HVV WKDQ KDOI ‘ 1HYHU ‘ 1R Information

Response to Treatment:
‘ Improving with WUHDWPHQW ‘ 6WDEOH ZLWK WUHDWPHQW ‘ 1RW LPSURYLQJ ‘ Information

3ULPDU\ &DUH 3URYLGHUV 3&3V 2QO\

PCP Treatment Plan