



Coordination of Care and Release of Information Form

The coordination of care among treating providers is essential for safe and effective care. To share information applicable sections of this document and include signed consent for releasing information, as appropriate.

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| Date: |
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| Patient name: |
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| Date of Birth: |
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CareSource Member ID:



Current Medications (or attach list):

Adherence to Medications: • Most of the time • Half of the time • Less than half • Never • No information

Adherence to Appointments/Treatments: • Most of the time • Half of the time • Less than half • Never • No information

Response to Treatment: • Improving with treatment • Stable with treatment • Not improving • No information

Additional comments: _____

Provider signature: _____ **Date:** _____

CareSource has Case Managers available to assist with coordination of care. Please return a copy of this form to the email address associated with your location or call 1-844-438-9498 and a Case Manager will assist with care coordination efforts. Referrals may also be submitted via the P vied via the P vied via the P vied via t(R)5(244R9