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: □ Member has signed an authorized form allowing me to exchange pertinent information ***must be marked if information provided** □ Member 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: Fax: ( ) -	Telephone: Fax: ( ) -

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)		

Most Recent Hospitalizations Past Year □ check here if none in past year	
Hospital	Reason for admission

Adherence to Medications:

□ Most of the time □ Half of the time □ Less than half □ Never □ No information

Adherence to Appointments

□ 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

Primary Care Providers (PCPs) Only

PCP Treatment Plan

Behavioral Health (BH) Providers Only

BH Treatment Plan

Response to Treatment:
□ Outpatient Therapy □ Medication Management □ Intensive Outpatient □ Type of psychotherapy prescribed:_____

Follow-Up BH Plan:
Expected length of treatment □ <3 mos □ 3-6 mos □ 6-12 mos □ > 1 yr

□ Member will be seen for a follow-up in _____ day(s) _____ month(s)
□ Member declined behavioral health services □ No further treatment is needed at this time
□ Other _____

Provider signature: _____ Date: _____