Coordination of Healthcare Exchange of Information

The sharing of information around medication and treatment between patient's physical healthcare provider and behavioral healthcare provider are essential for safe, effective coordination of care. Please complete applicable sections of this document to provide information regarding member's care. Include signed consent from member for release of 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:	
Provider Information	
Primary Care Provider:	Behavioral Healthcare Provider:
Address:	Address:
City State ZIP code	City State ZIP code
Telephone: Fax: ( ) -	Telephone: Fax: ( ) -

Member Active Diagnoses (or attach list)		

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

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

Key Elements of Treatment Plan:

1._____

2._____

3._____

4_____

Adherence to Treatment:

□ All or most of the time □ Some of the time □ Not regularly □ Almost never or never □ No information