Health Coordination Information Exchange Form

Please complete the applicable sections of this form to provide information regarding your patient's care. Please include signed consent from your patient for the release of information, as appropriate.

Patient Information	
Patient's Name:	Patient's Member ID Number:
Date Form Completed:	Patient's Date of Birth:
Name of person completing form (print):	
Title of person completing form:	
Signature of person completing information:	
Provider Information	
Specialist Provider:	Primary Care Provider:
Address:	Address:
City State ZIP code	City State ZIP code
Telephone: Fax:	Telephone: Fax:

Patient's Active Diagnoses (or attach list)		

Patient's Medications You Prescribe (or attach list)		
Medication Name	Dose	How Taken

Most Recent Hospitalizations Past Year	**□ none in past year**
Hospital	Reason for admission

Key Elements of Treatment Plan:

1._____

2._____

3._____

4_____

Next follow up appointment: _____ Released from care: _____ Follow up as necessary: _____

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

Adherence to Treatment

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

Response to Treatment:

□ Improving with treatment □ Stable with treatment □ Not improving □ No information