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 information (print):	
Title of person completing information:	
Signature of person completing information:	
Provider Information	
Primary Care Provider:	Specialist 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

Reason for referral/prior treatments/pertinent information:

1._____
2._____
3._____
4_____

Adherence to Prior Treatment:

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

Adherence to Medications:

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

Response to Prior Treatment:

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