BEHAVIORAL/PHYSICAL/SOCIAL HEALTH COORDINATION FORM

		Date (month, day, year)	
Name of member		Date of birth (month, day, year)	
Health care provider		Behavioral health provider	
Address (number and street)		Address (number and street)	
City, State, Zip		City, State, Zip	
Telephone number ( )	Fax number ( )	Telephone number ( )	Fax number ( )
This form was filled out by			

The sharing of prescribed medication and treatment recommendations between this patient's physical healthcare provider and behavioral healthcare provider are essential for safe, effective coordination of care. Please complete the applicable section of this form and forward to the appropriate healthcare professional.
More information: mhsindiana.com

PATIENT CONSENT

Please check if you DO NOT want the following protected health information released: ☐ **Behavioral Health** ☐ **Substance Abuse** ☐ **HIV/AIDS**

This authorization will expire on _____. I authorize the use and/or disclosure of my protected health information as described above. I understand this authorization for release of protected health information is made to confirm my wishes. I understand that I may revoke this authorization at any time by giving written notice to the person or organization that is authorized above to release information. My healthcare provided by_____ will not be affected if I do not sign this form. This information disclosed by this release may be re-disclosed by the recipient and may no longer be protected.

Date (month, day, year)

Name of provider

☐ **Member declined to participate**

Signature of member

Signature of member

PHYSICAL HEALTH CARE PROFESSIONAL TO COMPLETE THE FOLLOWING

☐ **Medication log attached**

MEDICATION	DATE STARTED	PRESCRIBED DOSAGE	Allergies to medications:
1.			
2.			Current diagnosis
3.			
4.			Comments:
5.			
6.			

BEHAVIORAL HEALTH PROVIDER TO COMPLETE THE FOLLOWING

☐ **Medication log attached**

MEDICATION	DATE STARTED	PRESCRIBED DOSAGE	Allergies to medications:
1.			
2.			Current diagnosis
3.			
4.			Comments:
5.			
6.			

Please provide the following information regarding (Member name)	2. Is another appointment required? ☐ Yes ☐ No	If yes, date and time scheduled ☐ AM ☐ PM
1. Results of appointment, including any prescriptions ordered (attach forms as necessary)	3. Are there any special instructions for this member to follow? (please describe)	

BEHAVIORAL/PHYSICAL/SOCIAL HEALTH COORDINATION FORM

PHYSICAL HEALTH AND BEHAVIORAL HEALTH PROVIDERS TO COMPLETE THE FOLLOWING
Is the member experiencing any problems with the following:
☐ Housing resources
☐ Utility resources
☐ Access to food
☐ Access to health care services
☐ Transportation
☐ Social support, social norms and attitudes
☐ Exposure to crime, violence and social disorder
☐ Residential segregation and other forms of discrimination
☐ Access to mass media and emerging technologies
☐ Resources to meet daily needs
☐ Culture
☐ Availability of community-based resources in support of community living/opportunities for recreational and leisure-time activities
☐ Language/literacy
☐ Socioeconomic conditions
☐ Quality of education and job training
☐ Public safety
☐ Access to educational, economic and job opportunities