

Cruz Clinic and Integrative Psychology

Coordination of Care

Patient Name: _____ Date of birth: _____

Patient Consent to Exchange Information with my Primary Care Physician (to be completed by patient)

I, _____, **authorize / do not authorize** (CIRCLE ONE)
Cruz Clinic/Integrative to send this coordination of care form to my primary care physician.

Primary Care Doctor Name _____
Primary Care Doctor Address _____
Primary Care Doctor Phone _____
Primary Care Doctor FAX _____

_____ Please initial here if you prefer no coordination of care (this form will not be sent) and have received "Be Your Own Health Manager" information sheet.

To exchange information regarding my mental health/substance abuse treatment and medical healthcare coverage for coordination of care purposes as may be necessary for the administration and provision of my health care coverage. The information exchanged may include information on mental health care or substance care and or treatment such as diagnosis and treatment plan. I understand that this authorization shall remain in effect for the course of this treatment. I understand that I may revoke this authorization at any time by written notice to the above behavioral health provider. I also understand that it is my responsibility to notify my behavioral health provider if I choose to change my Primary Care Physician. I also understand that most health care insurance (under the new health care act) require coordination of care with your PCP prior to paying for services rendered.

Patient Signature _____ Date _____

Signature of Parent/ Guardian (If patient is a minor) _____ Date _____

Signature of Witness _____ Date _____

Information to be completed by Behavioral Health Provider

Clinicians: for an urgent or emergency situation, please call the primary care physicians in addition to sending form

(Provider Name) _____ at Cruz Clinic of Livonia / Integrative Psychology of Ann Arbor
Phone 734-462-3210 Fax 734-462-1024
DSM V Diagnosis code & name: _____
Symptoms: _____
Treatment Type _____ Frequency _____ Length of TX _____
Medication (s) Prescribed: _____
 screening tools attached (check here)
 psychosocial assessment attached (check here)

Comments: _____

Conclusion of mental health/ Substance treatment

_____ Date of last session _____ treatment completed? Yes _____ No _____
_____ Notification of prescription or change in medications (see comments)
_____ Summary of care attached (check here)
_____ Comments: _____

Clinician Signature _____ Credentials _____ Date _____

A COPY OF THIS FORM MUST BE SENT TO THE PRIMARY CARE PHYSICIAN, RETAINING THE ORIGINAL IN THE PATIENT CHART. IF THE FORM IS SENT BY FAX, ATTACH CONFIRMATION THAT THE FAX WAS SENT.
DATE SENT _____ SENT BY INITIALS _____ FAX OR MAIL

Rev: 8-28-18 (DZ)