Parkland Community Health Plan

Coordination of Care/Treatment Summary

Coordination of care between behavioral health and medical providers is critical in ensuring members with co-occurring health conditions receive appropriate care. In order to facilitate provider communication, PCHP makes this form available for provider use. Providers are responsible for ensuring any required Release(s) of Information have been obtained and are on file.

Member Name _____ DOB _____ Member ID _____

SECTION A (Completed by BH provider)

1. I am treating for the following BH (MH/SUD) condition(s) and/or diagnoses (list all)

2. The patient is taking the following medication(s) (list all prescribed and OTC medications, with dosage and frequency as applicable)

Prescriber _____

3. Please list any other pertinent information needed to adequately coordinate care: (i.e. abnormal lab results, changes in condition or treatment plan, etc.)

BH Clinician _____

BH Clinician Signature _____

Provider Name / Site Name _____

Address _____

_____

_____

Phone _____

Fax _____

Date this form completed _____

SECTION B (Completed by Medical provider)

1. I am treating for the following medical and/or BH (MH/SUD) condition(s) and/or diagnoses (list all)

2. The patient is taking the following medication(s) (list all prescribed and OTC medications, with dosage and frequency as applicable)

Prescriber _____

3. Please list any other pertinent information needed to adequately coordinate care: (i.e. abnormal lab results, changes in condition or treatment plan, etc.)

Medical Provider _____

Medical Provider Signature _____

Provider Name / Site Name _____

Address _____

_____

_____

Phone _____

Fax _____

Date this form completed _____