Coordination of Care Consent Form

REQUIRED FORM:

This form is a required document in the client file. Care Coordination is an essential part of providing behavioral health services to ensure client needs are met, including physical health needs. These forms facilitate communication with primary care at intake regarding significant changes with medication and at client discharge. Within 30 days of opening to services, it is important that client is connected to primary care provider (PCP).

WHEN:

Completed at Intake, but no later than 30 days from admission

COMPLETED BY:

Authorized agency representative

REQUIRED ELEMENTS:

There are two forms to facilitate communication with primary care.

FORM 1: **Coordination and/or Referral of Physical & Behavioral Health Form** (4 page form)

- Provider complete form at intake, but no later than 30 days from admission
- Provider obtain written consent from the client/guardian
- For clients that do not have a PCP, provider will connect them to a medical home
- Provider will send completed form to PCP for completion.
- Provider shall check the appropriate box at the top of form (on pg 1 of 4), noting if this is a:

Referral for ***Physical Healthcare****

Referral for ***Physical Healthcare*** & ***Medication Management****

Referral for ***Total Healthcare*** or

Coordination of Care notification *only*

*if the referral is for ***Physical Healthcare*** or ***Physical Healthcare*** & ***Medication Management***, please enter your program name in the blank space and select the appropriate box for program type: Mental Health or Alcohol and Drug

Section A: Client Information

Complete all client information as prompted by the form.

Section B: Behavioral Health Provider Information

Complete this section with your program's information as prompted.

Section C: Primary Care Physician Information

If the client has a Primary Care Physician, provide the PCP's relevant information in this section. If the client does not have a PCP, provide the information of the doctor or clinic to which client is being referred.

Section D: (For Primary Care Physician Completion)

Signature of Individual or Legal Representative:

Client or client's legal representative provides signature and date in this section.

Expiration:

Provide an expiration date, event or condition (i.e. discharge) for the authorization. Client, with the guidance of authorized agency representative, will select the type of information they wish to authorize for release by checking all applicable check boxes.

I Would Like a Copy of This Authorization:

Client or authorized agency staff will check the corresponding yes or no check box indicating whether the client wishes to receive a copy of the authorization.

This form should be faxed to client's Primary Care Physician or Medical Home to which client is being referred.

FORM 2: <u>Coordination of Physical and Behavioral Health Update Form</u> (1 pg form)

- Provider will complete form if there are significant changes to client medication (change in dosage of current medication reported at the discretion of psychiatrist).
- On upper right side box of form—"Date Release of Information Signed" provider are to enter the ***original*** date that was signed by the client/guardian on the ***Coordination and/or Referral of Physical & Behavioral Health Form*** (on pg 3 of 4)
- Provider will send **completed** form to PCP when client is discharged from program (this form shall be completed prior to completion of a discharge summary).

NOTES:

- Users of these forms are responsible to have a system in place to track:
    1. **Expiration Date** of the authorization
    2. **Written Revocation** of the authorization
    3. **Discontinue** of the authorization upon termination of treatment (60 days after discharge)