

**Cruz Clinic/Integrative Psychology - Coordination of Care**

**Patient Name:** \_\_\_\_\_ Date of birth: \_\_\_\_\_

**Behavioral Health Provider/Primary Care Physician Communication Form  
Patient Consent to Exchange Information** (to be completed by patient)

I, \_\_\_\_\_, **authorize / do not authorize** (CIRCLE ONE)  
Cruz Clinic 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** \_\_\_\_\_

\_\_\_\_\_ Patients please initial if you prefer no coordination of care and 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 \_\_\_\_\_

**Provider Information (To be completed by Behavioral Health Provider)**

(Provider Name) \_\_\_\_\_ at Cruz Clinic  
17177 N. Laurel Park Drive, Ste 131, Livonia, MI. 48152 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: \_\_\_\_\_

**For Urgent or emergency situation, please call the primary care physicians In addition to sending form**

**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: \_\_\_\_\_

\_\_\_\_\_  
**Provider's Signature** \_\_\_\_\_ Credentials (MD, PA ,NP, or Therapist) \_\_\_\_\_ Date \_\_\_\_\_

**A COPY OF THIS FORM MUST BE SENT TO THE PRIMARY CARE PHYSICAIN, RETAINING THE ORIGINAL IN THE PATIENT CHART. IF THE FORM IS SENT BY FAX, ATTACH CONFIRMATIONN THAT THE FAX WAS SENT.**  
**DATE SENT \_\_\_\_\_ SENT BY INTIALS \_\_\_\_\_ FAX OR MAIL**

**Please File in Patient's Chart**