



Coordination of Care and Treatment Summary

In accordance with acceptable medical practice, Dell Children's Health Plan requires network behavioral health care providers, primary care providers and other appropriate medical providers involved in a member's treatment to coordinate care. Please complete this form and send it to the appropriate other provider(s) treating this member after obtaining written patient consent in compliance with all applicable state and/or federal regulations.

Member name: _____	Date of birth: _____
A. Your Information	
Name: _____	Phone: _____
Practice name: _____	Address: _____ _____
B. Other Provider Information	
Name: _____	Address: _____ _____
Phone: _____	Fax: _____
C. Member Clinical Information	
1. I am treating the member for the following diagnosis(es): _____ _____	
2. The member is taking the following prescribed medication(s) I prescribed: _____ _____	
3. (For behavioral health providers only) The member is engaged in the following psychotherapeutic intervention(s): _____ _____	
Frequency of intervention(s): _____	
4. Coordination of care issues/other significant information affecting medical or behavioral health care: _____ _____	
Signature: _____	Date: _____
Fax or mail form to [list other provider(s)]: _____	Date mailed or faxed: _____