Behavioral Health and Primary Care Communication Tool Kit

The following sample forms are tools intended to help facilitate communication between providers and may serve as a model for the exchange of clinical information between Behavioral Health and Primary Care Providers. Cigna-HealthSpring believes that through communication and coordination of care, disruptions and delays in treatment may be prevented and poor health outcomes averted.

(Cigna-HealthSpring Health cannot provide you with legal advice on the use of any release form for your practice. The following is a sample only. You should obtain the advice of legal counsel for your practice).

CONSENT FOR RELEASE OF CONFIDENTIAL INFORMATION TO PRIMARY CARE PHYSICIAN

I, ______________________________hereby authorize ______________________
Member's Name Practitioner's Name

to disclose to my Primary Care Physician, _________________________all clinical information about me as may be necessary to permit my Primary Care Physician to monitor the continuity of my care and to inform my Primary Care Physician of my health status. This authorization becomes effective ______________, and may be revoked by me in writing at any time, with the exception of any actions already taken to coordinate my care. Unless previously revoked by me, this authorization automatically terminates the earlier of six (6) months from the effective date. I understand that this authorization does not extend to the release of any AIDS/ HIV information unless I also placed my initials here _______. I further understand that the information authorized by this release will be released to the authorized representative only, for purposes noted above. I understand I (or my legal representative) am entitled to a copy of this authorization form for my records.

SAMPLE

____
Legal Signature of Participant or Legal Guardian Date

SAMPLE LETTER FOR BEHAVIORAL HEALTH PRACTITIONERS' COMMUNICATIONS WITH PRIMARY CARE PHYSICIANS

SAMPLE

Date _______________
Primary Care Physician Name
Primary Care Physician Address
City, State and Zip Code

Re: *Participant's Name*

Dear Dr. ____________________:
Your patient, ________________________ has identified you as their primary care physician. In my work with Mr./Mrs./Ms _____________________________ we have discussed the importance of coordinating an individual's total health care across health care professionals. In response to this discussion, _______________________ has given his/her consent for me to contact you, introduce myself as his/her behavioral health care practitioner and work directly with you when necessary.

At the present time __________________________ has been in care with me since ______. In my continued work with ____________ I will be in touch with you as changes occur which would be pertinent to our coordination efforts.

As ______________________________'s overall health care is of primary importance, I will be available to you and can be reached at ___________________________. I look forward to our working together on an integrated approach for an optimal treatment outcome.

Respectfully,

Behavioral Health Provider's name

BEHAVIORAL HEALTH PRACTITIONER/FACILITY TO PRIMARY CARE PHYSICIAN COMMUNICATION FORM

SAMPLE

Participant Name
of Birth

Participant ID #

Participant Date

TO:

Contact ____________________________
____

Phone ____________________________
____

Fax ____________________________
____

Release of Information Obtained: Yes No

FROM:

Contact

Phone

Fax

Address:____________________________
____

Date Admission or Treatment Began

Date Facility Discharge or Last Seen

Behavioral Diagnosis or Condition (note if Initial or Final)	
(Mental Health/Substance Use)	
Treatment Recommendations (note if Planned or Completed)	
Ancillary Tests / Evaluations / Findings	
Behavioral Prescriptions and Dosages	
Outcome of Treatment	
Degree of problem resolution	**Indications for re-referral**
Discharge medications	**Follow-up recommendations**
Clinical Issues (e.g. compliance, stability, medication issues, co-morbid conditions)	