COMMUNITY MENTAL HEALTH & SUBSTANCE ABUSE SERVICES OF ST. JOSEPH COUNTY

CMHSAS-STJ

Coordination of Care

IDENTIFYING INFORMATION				
NAME	DOB		CASE #	GENDER
ADDRESS				

DOCUMENT DATE

DATE LAST SEEN

HEALTH PLAN

PRIMARY CASEHOLDER

Unassigned

CMHSP CONTACT

CMHSP PHONE

CMHSP FAX

COORDINATION OF CARE RECIPIENT INFORMATION

ADDITIONAL TEXT TO APPEAR IN HEADER OF COORDINATION OF CARE FORM

☐

☐ Above Patient Receives Treatment from CMHSAS of St. Joseph County and Coordination of Care and Services is Requested.

☐ Above Patient Receives Treatment from CMHSAS of St. Joseph County and Coordination of Care and Services is Requested. To assist with integrated healthcare, could you please provide us with the following information:
 1. Diagnosis with codes
 2. Medication list
 3. Last labs
 4. Date of last physician visit

TYPE OF COMMUNICATION

☐ Initial Assessment
DATE:

☐ Discharge From Treatment
DATE:

☐ Discharge From Hospital
DATE:

☐ Admission to Hospital:
WHERE:
DATE:

☐ Partial Hospital Admission:
WHERE:
DATE:

☐ Change in Care/Medication Change
DATE:

☐ Other:

☐ Psychiatric Evaluation
DATE:

☐ Annual Review of Treatment Plan
DATE:

INTEGRATED SUMMARY OF SYMPTOMOLOGY, NEEDS, AND RECOMMENDATIONS

RECOMMENDATIONS FOR SAFETY/RISK AND/OR HEALTH CONCERNS

PRIMARY PSYCHIATRIC DIAGNOSIS

ALL MEDICATIONS

CLIENT'S VITAL SIGNS - LAST 0 COLLECTION(S)
No Vitals Records Found

COMMENTS

☐ Consent to Share Behavioral Health Information
☐ Letter Generated but not sent due to Consent
☐ Letter Generated but no PCP
☐ Goals from Treatment Plan (Included)

TREATMENT PLAN GOALS

DOCUMENTATION	
Date	Title

SIGNATURES

STAFF SIGNATURE / CREDENTIALS

DATE