Samaritan Counseling Center of West Texas
Healthcare Coordination Form

Client Name ________________________________ Date of Birth ______/______/_______

<u>Dear Center Client</u>: Research indicates there is a close relationship between physical and mental health and that better treatment outcomes will be achieved if your therapist and your primary care physician coordinate your care. Many physical complaints are rooted in psychosocial issues and physical symptoms can be signs of mental stress. This coordination and consultation is especially important if you are on medication. Medication may have side effects that could affect your mood, ability to concentrate and fully participate in therapy. This form is to give your consent to consult with your psychiatrist, primary care physician, nurse practitioner, or other providers to ensure you receive the best possible care from the Samaritan Center.

Please check one:
_____I would like for you to coordinate my care with my other healthcare providers

_____I do not have a Primary Care Physician or see any other doctors at this time

_____I do not give permission for consultation with other providers at this time

Physician Name: ______________________________ Clinic Name: ______________________________________
Telephone: ___________________

Physician Name: ______________________________ Clinic Name: ______________________________________
Telephone: ____________________

Physician Name: ______________________________ Clinic Name: ______________________________________
Telephone: ____________________

____
Client (or guardian) signature Date

____
Therapist signature Date Therapist name printed

DEAR PHYSICIAN: You have been identified as this client's medical provider. We want to inform you that your patient was seen for outpatient psychotherapy at the Samaritan Center and has authorized us to consult with you as necessary regarding their treatment.
Please acknowledge below that this client is a patient of yours and that you will be available for consult.
1. _____ We have no record of having provided recent medical care to the client.

2. _____ This is our patient and we will be available for consult if needed.

3. _____ This patient is currently prescribed the following drugs:

Physician Comments:

Physician Signature ____ Date _______/_______/________

Please return by mail of fax to:
Samaritan Counseling Center of West Texas
P.O. Box 60312
Midland, TX 79711-0312
Office: 432-563-4144 // Fax 432-561-8611

Samaritan Use Only:
Date Faxed to Dr: ______/______/________
Samaritan Employee Initials _______