Samaritan Center

Healthcare Coordination Form

Client Name ____ Date of Birth ______/______/_______

Dear Center Client: Research indicates there is a close relationship between physical and mental health and that better treatment outcomes will be achieved if your provider 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 treatment. This form is to give your consent to consult with your psychiatrist, couselor, 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: ____

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Client (or guardian) signature Date

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Staff signature Date Staff name printed