Clinician Collaboration Form

Patient name_____ DOB: _____

Has the *Authorization to Release Information Form* been completed and documented in the patient's chart?

Yes____ No_____

Reason for collaboration:

I am ☐ referring or ☐ following the above-named patient for _____

Diagnosis: _____

Related medical history: _____

Current medications:

_____

_____

Lab information

Labs completed: _____

Labs needed: _____

Additional information:

_____

_____

_____

_____

_____

_____

Suggestions for care/Identified needs:

_____

_____

_____

_____

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Physician/Practice name: _____

Phone number: _____ Fax: _____

Email: _____

Signature of person completing form: _____ Date: _____

Magellan Healthcare, Inc. manages mental health and substance abuse benefits for most AmeriHealth members.

AmeriHealth HMO, Inc.