



### 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.*