GlobalHealth

Medical - Behavioral Health Coordination of Care Form
Date: / /

Member Name:	**DOB:**
Member ID:	Plan Name :
Member Phone:	Member Address:
Referring Physician :	Office Number/Contact:
Medical Diagnosis:	Behavioral Health Diagnosis:
Medical Medications:	Behavioral Health Medications:

Reason for Referral (list reason, requested assistance needed, member's needs, etc.):

Form Completed by: Phone: Email:	Referred To: **GlobalHealth** Phone: **(405) 280-5786** Fax: **(405) 758-4318**

Outcome Details – Date: / / *(To be completed by GH staff)*
Referral to Psychiatrist (name/phone):
Referral to Commercial Therapist (name/phone):
Referral to Medicare Therapist (name/phone):
Scheduled Routine Appointment(s) (ProvName/Date of Appt):
Scheduled Urgent/Emergent Appointment(s) (ProvName/Date of Appt):
Referred to ER (list hospital):
Unable to Reach Member (2 call attempts):
Member already in Treatment (ProvName/Phone):
Member declined assistance/referral(s):
Member admitted to MH/SA treatment (list ProvName): ☐ Acute ☐ MedDetox ☐ RTC ☐ PHP ☐ IOP
Additional Details: