MEDICAL MUTUAL®

Continuity of Care Guidelines

Behavioral Health

The Behavioral Health Consultant is responsible for obtaining a signed consent form from the patient allowing the communication of important clinical information. If the patient consents to communication, the Behavioral Health Consultant is responsible for exchanging information regarding the patient's evaluation and care plan to the referring physician. The communication should be completed within 30 days of the initial evaluation.

Communication Components

The communication should contain the following components when applicable:

Clinical Evaluation

Pertinent features of the Behavioral Health Evaluation

Diagnostic Tests

Results of diagnostic studies and procedures that have been completed and recommendations for additional testing when applicable

Clinical Impression

Patient's diagnosis and/or differential diagnosis

Treatment Plan

Therapy rendered by the Behavioral Health Provider and ongoing recommendations (e.g, psychotropic medications, psychotherapy and/or referral to community resources)

Follow-Up

Recommendations concerning who should provide follow-up care and when those services should be performed.

Strict privacy and confidentiality policies are maintained that state our commitment to treating members in a manner that respects their rights and protects the confidentiality of personal health information and records.

Behavioral Health Patient Summary Form

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Referring Provider Information			
Provider Name (First and Last)	Phone Number	Fax Number	
Street Address	City	State	ZIP

Consulting Provider Information			
Provider Name (First and Last)	Phone Number	Fax Number	
Street Address	City	State	ZIP

Patient Information		
Patient Name (First and Last)	Date of Birth	Communication Preference ☐ Phone ☐ Email ☐ Mail

Presenting Problem and Symptoms

☐ Depressed Mood	☐ Hallucinations Delusions Disorganized Thinking	☐ Marital/Family Stress Trouble Coping	☐ Alcohol/Drug Use
☐ Mood Swings	☐ Anxiety/Panic	☐ Attention Problems	☐ Memory Problems

☐ Other:

Clinical Impression/Diagnosis

☐ Major Depressive Disorder	☐ Schizophrenia/ Thought Disorder	☐ Relational Problem/ Adjustment Disorder	☐ Substance Use Disorder
☐ Bipolar Disorder	☐ Anxiety Disorder	☐ ADD/ADHD	☐ Dementia/Cognitive Disorder

☐ Other:

Treatment and Follow-Up Recommendations

☐ Medication Management (state medications):

☐ Psychotherapy ☐ Individual ☐ Group ☐ Marital	☐ Referral to specialist for additional services (e.g., testing, addiction):

Authorization

I, _____ , hereby expressly authorize _____ [insert name of disclosing provider] to release and disclose all medical and counseling records associated with the symptoms referenced in this Patient Summary Form to _____ [insert name of receiving provider], for the purpose of coordinating my healthcare. I understand my records are confidential and cannot be disclosed without my written consent, unless otherwise provided for in state or federal regulations. This consent is subject to revocation at any time except to the extent that action has been taken in reliance on it. If not previously revoked, this consent will terminate upon _____ [insert termination date].

Signature (Patient or Legal Guardian)	Print Name (Patient or Legal Guardian)	Date