MACOMB COUNTY COMMUNITY MENTAL HEALTH - FOCUS
COORDINATION OF CARE LETTER

Name: **Case #:** **Case:**

Date of Birth **Home Phone** **Current Admission**

Address **Primary Program:**
Case Holder:

Coordination Of Care Letter

Identifying Information

Date **Completed By**

☐ CMH ☐ Medicaid QHP / Physician

Name:
Location:
Address:

City/State/Zip:

CMHSP Provider

CMHSP Contact CMH Phone CMH Fax

CMH Fill Out All Information Below

Type of communication

☐ Initial screening ☐ Discharge Discharge date:

☐ Admission to hospital ☐ Partial hospital admission
Where: Where:
Date: Date:

☐ Change in care ☐ Other:

Primary psychiatric diagnosis

Comments

Past medical history

All medications

General medical diagnosis

Completed By

MEDICAID QHP OR PHYSICIAN: Fill out all information below (and blanks above if known). This may be completed by office staff and a copy placed in the patient?s chart).

PHYSICIAN ONLY: Once complete, please fax this information to the Medicaid QHP.

Date

Recent major health care issues

Allergies

Current medications

Past medical history

Completed by

SAVE CANCEL