

Ryon Medical & Associates, LLC.
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318 Lacey Avenue
La Junta, CO 81050
(719)384-0303 Phone ~ (719)384-1033 Fax

COORDINATION OF CARE FORM

We wish to keep you informed of pertinent information on a mutual client we are currently providing Mental Health services to.

Primary Care Provider: _____ Fax #: _____

Patient Name: _____ Date of Birth: _____

Height: _____ Weight: _____

Has patient received a physical exam in the past 12 months? Yes _____ No _____

Today's Date _____

I do not have a Primary Care Provider: (Please Sign) _____

I do not want information released to my Primary Care Provider: (Please Sign) _____

DO NOT WRITE BELOW THIS LINE. OFFICE USE ONLY

PROVIDER: WE SUPPORT EPSDT AS REQUIRED BY BEACON HEALTH. PLEASE FAX THIS PATIENT'S MOST RECENT EXAMINATION, SCREENINGS, AND ASSESSMENTS TO OUR OFFICE AS SOON AS POSSIBLE.*

THANK YOU FOR YOUR KIND ASSISTANCE.

Primary DSM-V Diagnosis: Axis I _____

Current Medication and Dosages Prescribed:

1: _____

2: _____

3: _____

4: _____

Treatment Start Date: _____ Date of Last Appointment: _____

Expected length of treatment: _____

Attached, please find the following:

____ Notice of new medications or changes to current medications

____ Treatment plan information

____ Psychological/Psychiatric Evaluation

____ Consultation Note

____ Termination Note

*Please see attached release of records as members consent to exchange information.

*If you would like to discuss this patient's treatment, please contact me at the number above.

Sincerely,

Dawn

Mental Health Coordinator