

Saginaw County Community Mental Health Authority
Health Care Coordination & Communication Form

Date: _____ Patient to give Faxed Mailed

Patient Name: _____ DOB: _____

To: _____

From: Dr. Renee Clark Dr. Gary Vize Dr. Jae Cho Dr. Hashim Raza Dr. Philip Creps

Other: _____

Please add the following information to your Medical Record

SCCMHA has authorization to share this Mental Health information with you. Release copy may be attached.

The following individuals comprise this patient's Mental Health Treatment Team:

Psychiatrist: Dr. Renee Clark Dr. Gary Vize Dr. Jae Cho Dr. Hashim Raza Dr. Philip Creps

Nurse: _____ phone: _____

Case Manager/Support Coordinator: _____ phone: _____

Therapist: _____ phone: _____

Other: _____ phone: _____

Diagnosis: **New Diagnosis** _____

Medications Rx by psychiatrist: **This is a Medication change** _____

Psychiatric services are not required and other SCCMHA services are provided under the auspices of
G. Renee Thomas-Clark, DO, Medical Director

Psychiatric Hospitalization: Date: _____ to _____ Hospital: _____

NO FURTHER ACTION IS REQUIRED UNLESS A BOX BELOW IS MARKED

Rx **Physician Order** **Nurses/Nursing Order** **Notification** **Other**