FBHP IPN Medication Evaluation Referral Form

This form begins a process which facilitates Medicaid consumers getting a medication evaluation without having to go through an additional clinical intake.

Date: ________________

To: ☐ Jefferson Center for Mental Health (JCMH)
☐ Mental Health Partners (MHP)

Per the enclosed Release of Information (ROI), and the consumer's/parent's/guardian's consent below. I am contacting your Mental Health Center (MHC) for the purpose of coordinating care for this Member:

Member Name: ________________________ Medicaid ID: _________ Date of Birth: ________

FBHP IPN Provider: (please print)_______________________ Telephone: ______________
Agency (if applicable):_______________________________ Fax: ___________________
Address: ____
____

Enclosed is a copy of the following completed documentation:
☐ The completed Medication Evaluation Form
☐ Release of Information (within 30 days)

Please send the following if FBHP does not have them yet.
☐ Signed treatment plan (most recent)
☐ CCAR (not older than 1 year and updated to be current with any recent changes)
☐ Clinical Assessment (within 6 months or updated to be current with any recent changes)

I, ________________________________, authorize ☐ JCMH or ☐ MHCBBC to contact me to schedule a medication evaluation appointment. I understand that I will be expected to sign additional consent forms with the MHC for all legal guardians, social service case workers, &/or biological parents, if there is joint custody for any Medicaid Member under the age of 15 years.

Member/Parent/Guardian:__________________________________ Telephone: ____________
Address: ____
____

Member/Parent/Guardian Signature: ______________________________ Date: _____________

IPN Clinician Signature: ___________________________________ Date: _____________

Please complete this form and fax to FBHP clinical care management staff at (719) 538-1439.

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