PROVIDER COMMUNICATION

TYPE OF COMMUNICATION REQUESTED:
☐ **INFORMATION EXCHANGE ONLY** ☐ **CONSULTATION (Use Page 1)**
☐ **REFERRAL** ☐ **TRANSFER** ☐ **NOTIFICATION OF DISCHARGE (Use Pages 1 and 2)**
***Indicates required sections for ALL communication types**

SENDER*	**RECIPIENT***
Agency: _____	Agency: _____
Contact Person: _____	Contact Person: _____
Phone Number: _____	Phone Number: _____
Fax Number: _____	Fax Number: _____
E-mail: _____	E-mail: _____

RENDERING PROVIDER INFORMATION*

Name: _____ Title: _____

Contact Information (if different from Sender information above): _____

Provider Signature: _____ Date: _____

CLIENT INFORMATION*

Name: _____Medi-Cal CIN:_____ DOB: _____

Address: _____ Phone Number: _____

Gender: _____ Client's Preferred Language: _____ Caregiver's Name (if applicable): _____

Caregiver's Preferred Language: _____ Caregiver's Phone Number: _____

Payor Source**:** ☐ Medi-Cal Only ☐ Medicare Only ☐ Medi-Medi ☐ Uninsured ☐ Other _____

DOCUMENTS ☐ **PROVIDED – or –** ☐ **REQUESTED*** *Note: The release of Protected Health Information may require a signed client authorization under certain circumstances.*

Check as many boxes as applicable: ☐ Authorization ☐ History & Physical ☐ Laboratory (specify) _____
☐ Assessment ☐ Assessment Summary ☐ Treatment Plan ☐ Treatment Summary ☐ Problem List ☐ Medication List
☐ Progress Notes ☐ Consultation Outcome ☐ Discharge Plan ☐ Other (specify) _____ ☐ None
Explanation/Additional Comments: _____

_____

_____

COMPLETE THE SECTION BELOW THAT CORRESPONDS TO THE TYPE OF COMMUNICATION REQUEST

Information Exchange Only – Required Information

Sender must complete form through "Documents Provided or Requested" section above. No additional information necessary.

Request for Care Consultation - Required Information

Description of question or request: _____

_____

_____

DMH USE ONLY
Name: **DMH ID#:**
Agency: **Provider #:**
Los Angeles County – Department of Mental Health

Original Copy – Receiving Agency
Copy – Initiating Agency

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Notification of Referral for Services - Required Information

Reason(s) for Referral: ☐ Health Care Services ☐ Substance Use Disorder Services ☐ Housing Assistance ☐ Employment Assistance ☐ Non-specialty Mental Health Services ☐ Specialty Mental Health Services (see below) ☐ Other: _____

Explanation/Additional Comments: _____

_____

Additional Information Required for Specialty Mental Health Services Referral**

Recently released (within past 15 days) from: ☐ Jail ☐ Juvenile Hall ☐ Inpatient facility

☐ Current thoughts of suicide/self-harm? ☐ Current thoughts of homicide/harm to others? ☐ Evidence of grave disability?

Is the individual currently taking psychiatric medication for which a refill may be necessary? ☐ Y ☐ N If yes, # of days remaining? _____

**Medi-Cal Managed Care Plans: For urgent referrals, please use the Behavioral Health Screening Form to Obtain Behavioral Health Assessment. For routine referrals, either form may be used.

Notification of Transfer of Services - Required Information

Discharge Date: _____ Description of client's current services:_____

_____

Reason for Transfer of Care: ☐ Client in need of a higher level of care ☐ Client in need of a lower level of care

☐ Client would like services in a different Service Area ☐ Client in need of services not offered at agency

☐ Client no longer meets specialty mental health criteria ☐ Other:_____

Rendering Provider's Supervisor: _____ Title: _____

Signature: _____ Date: _____

Notification of Discharge from Care - Required Information

Discharge Date: _____

Reason for Discharge: ☐ Treatment goals met ☐ Assessment does not indicate need for services

☐ Client requests termination of services ☐ Client in need of a lower level of care ☐ Needed services are unavailable

☐ Client absent from services (missed appointments/unable to contact) ☐ Further services would not produce additional benefits

☐ Client unwilling to participate in necessary payment, billing, and reimbursement

☐ Other: _____

Discharge Summary: _____

_____

_____

FOR RECIPIENT USE ONLY

Instructions: **Fax this form to the number and person indicated at the top of the form**

Outcome of Transfer/Referral: ☐ Client Accepted for Services ☐ Client Did Not Show* ☐ Client Declined Services*

☐ Other: _____ *Transferring/referring provider to follow up with individual

Assigned Case Manager/MD/Therapist Name: _____ Phone: (_____) _____

Date disposition sent to transfer/referral source: _____/_____/_____

DMH USE ONLY

Name: **DMH ID#:**

Agency: **Provider #:**

Los Angeles County – Department of Mental Health

Original Copy – Receiving Agency
Copy – Initiating Agency

PROVIDER COMMUNICATION

PROVIDER COMMUNICATION FORM INSTRUCTIONS

Purpose This form is for use by providers to communicate about client services and care. Specifically, the form can be used for the following reasons:

Communication Type	Communication Purpose
Information Exchange for Coordination of Care	To facilitate exchange of information between providers regarding a shared patient/client for coordination of care.
Transfer of Care	To request confirmation of the transfer of responsibility for patient/client care from one treating mental health provider to another when the current mental health provider is discontinuing services.
Referral for Services	To request services for a patient/client not provided by the provider/agency.
Care Consultation	To request the clinical expertise or opinion of another provider regarding treatment of a patient/client currently under the care of the requesting provider.
Discharge from Care	To notify another treating provider when the current treating provider has discontinued patient's/client's services. For information only; does not indicate a transfer of responsibility for patient/client care or require feedback or follow-up unless desired by recipient.

Completion Instructions

The following sections are required for all communication types.

Type of Communication Requested:
- Select the reason for using this form.

Sender:
- The person completing the form should fill in their information as requested on the form.

Recipient:
- The person completing the form (Sender) should complete the information for who the form is intended to be sent (Recipient).

Rendering Provider Information:
- If the agency using this form does not have rendering providers, this section should be used by the person who is making the request on behalf of the individual/client.
- Fill in rendering provider name and title. If person completing the form is not the rendering provider, contact information for the rendering provider should also be completed.
- Provider signature and date should always be completed.

Client Information:
- Fill-in the specific client information requested on the form.
- If appropriate, enter in the caregiver's name, preferred language, and phone number. These fields are not required to be completed.
- Payor Source: only one box should be checked; if "Other" is checked, fill in the specific payor source information.

Documents Provided or Requested:
- The release of Protected Health Information may require a signed authorization from the client or his/her representative. Individuals completing this form are advised to refer to their agency policy when making this determination.

- Check whether the documents listed are provided with the communication or requested from the recipient.
- Check off the information that is being requested or provided. Multiple boxes may be checked and additional comments may be provided. If "Laboratory" is checked, please identify the types of labs. If "Other" is checked, please specify.

Of the sections following, only complete the one that is listed as "Required Information" for the communication type for which the form is being completed. After completing the required section, no further information is needed and the form is complete.

Information Exchange Only – Required Information:
- If the form is being completed only for the purpose of information exchange, no further information is required.

Request for Care Consultation – Required Information:
- Provide a written description of the question or request.

Notification of Referral for Services – Required Information:
- Check the reason for referral. More than one box may be checked if offered by the recipient, and comments can be provided. If "Other" is checked, please specify.
- If the referral is for Specialty Mental Health Services, complete the "Additional Information" section.
- Medi-Cal Managed Care plans and providers referring a patient/client for an urgent appointment must use the Behavioral Health Screening Form to Obtain Behavioral Health Assessment referral.

Notification of Transfer of Services – Required Information:
- Complete the discharge date and include a description of the client's services.
- Check the reason for transfer of care. If "Other" is checked, please specify.
- The name, title, and signature of the rendering provider's supervisor are required.

Notification of Discharge from Care – Required Information:
- Complete the discharge date and reason for discharge. If "Other" is checked, please specify.
- Provide a summary of the discharge in the space provided on the form.

For Recipient Use Only:
- If sending the Provider Communication form, do not complete this section.
- If receiving the Provider Communication form for the purpose of Referral or Transfer:
    - Check the outcome of the transfer or referral. If "Other" is checked, please specify.
    - Complete the assigned case manager/MD/Therapist name and contact information.
    - Complete the date that the disposition was sent to the transfer or referral source, and fax the form to the contact person listed in the "Sender" portion of the form.

NOTE: Sharing information must comply with all HIPAA rules. DMH Directly Operated staff should refer to DMH Policy & Procedures related to HIPAA Privacy. Other providers should refer to their own legal counsel and policies.

Filing Procedures for DMH:
- Paper Chart: File chronologically in Section 2 Correspondence of the Clinical Record
- IBHIS: Scan into the Correspondence folder.