Dana Turnbull, Ph.D.

H. E. B. Behavioral Medicine
Certified Eating Disorder Specialist
National Register of Health Service Psychologists

Healthcare Coordination Form

To:_____ Date:_____

RE:_____ Phone:_____

DOB:_____ Fax:_____

I am currently seeing the above patient for:
Individual Therapy Family Therapy Nutrition Counseling Couples Therapy

Pain Management Other:_____

The patient's Axis I diagnosis is:
Major Depressive DO Bipolar DO Anxiety DO Adjustment DO

Eating DO Substance Abuse DO Other_____

I have requested the patient see you for:
Psychotropic Medication Evaluation Continued Med Management

R/O Physical Causes of Psychiatric SX Physical Exam Labs/follow up:

Other:_____

Other Concerns:
Potential harm to self/others Noncompliance Medication Side Effects

Psychotic SX Information Only Other :_____

Comments: _____

CONSENT FOR RELEASE OF INFORMATION

I hereby authorize the release of the above medical information to the above listed physician(s). I understand that the release of this information is to permit my healthcare providers to coordinate my care. This authorization becomes effective on the date signed and expires six months later, unless revoked by me previously in writing. Additional information may be provided to the above recipient only with signed consent from me. I further understand that I have the right to receive a copy of this authorization upon my request.

_____

Signature of Patient (16 or older), Parent, or Legal Guardian Date

305 Miron Drive, Southlake, TX 76092* 817.571.2899* 817.571.9879 (fax)