AmeriHealth NEW JERSEY

Clinician Collaboration Form

Patient Name:	Patient Date of Birth:
Clinician Name:	
Clinician Address:	
Clinician Phone/Fax:	

Dear Colleague:
I saw the above-named patient, who gave an authorization to release the following information,
on _____ for _____
(Date) (Reason/Diagnosis)

Brief Summary (if indicated): _____

CURRENT TREATMENT (INTERVENTIONS BY SENDING PRACTITIONER):

☐ Psychotherapy ☐ Patient Refused Medication

☐ Medication(s) Prescribed: _____

Lab Tests: ☐ CBC ☐ Thyroid Studies ☐ Chem Profile ☐ EKG ☐ Lipid Profile ☐ Serum drug level (specify drug)
☐ Other: _____

Diagnostic Tests:

Treatment terminated (date/reason):

OTHER TREATMENT RECOMMENDATIONS (INTERVENTIONS REQUESTED OF RECEIVING PRACTITIONER):

The patient has ☐ has not ☐ received a copy of this form. If you have any questions or would like additional information, please contact me. Thank you.

Clinician Signature:	Date Sent/Faxed:
Clinical Phone #:	