Ellen Martin Logan, Ph.D.
Licensed Psychologist

Pine Crossing
6030 Bethelview Road
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COORDINATION OF CARE

Name of PCP or current physician: _____

Physician office address: _____

Physician office phone number: _____

Date of last medical exam: _____

List current medications, and for each explain how often you take it, reason you take it, and who prescribed it:

_____

_____

_____

_____

_____

_____

_____

_____

***Your signature below is necessary if you have managed care, and is not necessary if you do not.**

Your managed care company has requested that I coordinate your treatment with your Primary Care Physician. Please indicate below if you authorize my communication with your PCP or if you do not.

Please sign and date <u>one</u> of the following statements below:

(A) _____ I give Dr. Ellen M. Logan permission to contact and communicate with my PCP listed above.

Date: _____

(B) _____ I **do not** give Dr. Ellen M. Logan permission to contact and communicate with my PCP listed above.

Date: _____

If your coverage does not involve a managed care company or if you are not using insurance benefits, please indicate below if you would like me to consult with your physician about your treatment. Please sign and date.

Name: _____ I request that Dr. Ellen M. Logan consult with my physician's office about my case.

Date: _____