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## Medical/Behavioral Health Provider to School Personnel – Communication Form

Name/credentials of Provider completing form: Agency/Practice Name:

WIT				
H MENI	Phone #:			
AL HEA	Fax #:	Physician:		
3	Email:			
HE WHOLE CHILD	Best way to reach: ☐ Phone ☐ Fax ☐ Email	Today's Date:		
III IVIIOLI OIIILD				
Student Name:		DOB:	Grade:	
Home School District:		Current Educational Placement, if known:		
Primary School Contact Name: (with whom information will be shared)		School Contact phone/fax/e-mail:		
*Parentally signe	d HIPAA form must be completed. Please attach.			
Relevant concern	/diagnosis/condition(s):			
How long have you been treating the student for this condition?		Frequency of appointments?		
		Date of last office visit:		
Is student actively Comment:	y participating in treatment/therapy? $\ \square$ No $\ \square$	Yes		
Other known pro	viders:			
How does this co	ndition impair the student's ability to participate in	classes in school?		
Share ideas that o	could be considered to support the student in scho	ol:		
Are there any school activities in which you feel the student should not participate? Reason?				
When would you anticipate improved function? Would the student still need special consideration?				
Parents' understa	anding and perception of the situation?			
Other pertinent in	nformation?			
Copy to: Student	or Patient Medical File			

Collaborative Care committee – permission granted for universal use. Any suggestions for change should be reviewed by the committee. Contact email: callan@monroecounty.gov