Coordination of Care

Please circle the choice that best fits your current medical situation.

Do you currently have any of the following diagnoses?

1) Diabetes	yes	no
2) Coronary Artery Disease	yes	no
3) Stroke, including ischemic stroke and intracranial hemorrhage	yes	no
4) Chronic Kidney Disease (Stages 4 and 5) and End Stage Renal Disease	yes	no
5) Congestive Heart Failure	yes	no
6) Major Depressive Disorder	yes	no
7) Any other mental illness/mental health diagnosis	yes	no

If you answered yes to any of these questions, what treatment do you receive for this condition(s)?

_____

_____

Who is the physician(s) treating you for this condition(s)? (Name, Address, Telephone number).

_____

_____

Do you give Kirstin R. Abraham, LCSW permission to speak to the treating provider(s) listed above regarding your care and treatment? Yes No

If yes, please remember to complete the additional consent form entitled "Authorization" on the website www.indiantrailtherapy.com under the tab Helpful Forms for each provider that you are currently seeking treatment from.