Behavioral Health Communication Form to Primary Care Provider

ACTION REQUIRED ☐ **ACTION NOT REQUIRED** ☐

Patient Information

This patient is currently receiving behavioral health services and has consented to share the following information with his/her PCP.

Patient Name:_____ DOB_____/____/_____

Attached is a signed copy of the release of information_____Yes_____No_____

Behavioral Health Condition(s)

This patient is being treated for the following behavioral health conditions(s): list all diagnoses

_____

_____

_____

This patient has the following substance abuse issue(s): (if applicable)

_____

Medications

Medication Start Date/End Date

_____

_____

_____

Labs

Labs Start Date/End Date

_____

_____

_____

Next Office Visit

This patient is scheduled to return on:

Additional Information

Additional information and description of any special concerns:

_____

_____

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