Primary Care Provider/Behavioral Health Provider Communication Form

In an effort to increase communication and promote care coordination between providers, we ask that you review and complete the following information.

Member Name: ____

DOB: ____

A signed copy of the release of information (ROI) must be attached to this form. Indicate date of expiration of ROI: ____

Section A: Completed by Primary Care Provider	Section B: Completed by BH Provider
1. The patient is being treated for the following medical problem(s) and/or diagnoses: (list all) ____________________ ____________________ ____________________ ____________________ ____________________ ____________________	1. The patient is being treated for the following behavioral health problem(s) and/or diagnoses: (list all) ____________________ ____________________ ____________________ ____________________ ____________________ ____________________
2. The patient is taking the following medication(s): (list all, including OTC) ____________________ ____________________ ____________________ ____________________ ____________________ ____________________	2. The patient is taking the following medication(s): (list all, including OTC) ____________________ ____________________ ____________________ ____________________ ____________________ ____________________
Prescriber: _____________________________	Prescriber: _____________________________
3. Please describe any special concerns (i.e., include abnormal lab results): ____ ____ ____ ____ ____	3. Please describe any special concerns (i.e., include abnormal lab results): ____ ____ ____ ____ ____
Primary Care Provider: _____________________ Address: _________________________________ Phone: ___________________________________ Date this form completed: ___________________	Behavioral Health Clinician: __________________ Address: _________________________________ Phone: ___________________________________ Date this form completed: ___________________