PRIMARY CARE PROVIDER (PCP)/ BEHAVIORAL HEALTH (BH) PROVIDER COMMUNICATION FORM

In an effort to increase communication and promote care coordination between providers, we ask that you please 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

1. The patient is being treated for the following medical problem(s) and/or diagnoses *(list all)*:

_______________ _______________
_______________ _______________
_______________ _______________

2. The patient is taking the following medication(s) *(list all)*, including over-the-counter (OTC):

_______________ _______________
_______________ _______________
_______________ _______________

Prescriber: ____________________

3. Please describe any special concerns *(i.e. include abnormal lab results)*:

____
____
____

Primary Care Provider: ____________________

Address: ____________________

Phone: ____________________

Date this form completed: ____________________

Section B: Completed by BH Provider

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 over-the-counter (OTC):

_______________ _______________
_______________ _______________
_______________ _______________

Prescriber: ____________________

3. Please describe any special concerns *(i.e. include abnormal lab results)*:

____
____
____

Primary Care Provider: ____________________

Address: ____________________

Phone: ____________________

Date this form completed: ____________________

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