PCP to Behavioral Health Provider Communication Form

Date _____ Patient medical insurance ID # _____

Patient name _____ Patient date of birth _____

Reason for referral (if applicable) _____

Allergies (if applicable) _____

_____

Relevant past and present medication use

Name of medication	Dosage	Frequency	Date initiated/discontinued

Any adverse reactions to listed medications _____

_____

Relevant past and present medical conditions _____

_____

Current abnormal lab values (may attach separate copies of lab results sheets if preferred and include any thyroid and liver function tests) _____

_____

Primary care physician (PCP) name _____

PCP site and ID # _____

PCP telephone # _____

PCP fax # _____

Current, signed *Authorization to Release Information* form? ❑ Yes ❑ No Expiration _____

Signature of person completing form _____

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