Primary Care & Behavioral Health Provider Communication Form

To increase communication and promote care coordination between primary care (PCP) and behavioral health (BH) providers, we ask that you review and complete the following information.

Member Name _____

Member DOB _____

A signed release of information (ROI) must be attached to this form. ROI expires _____

Section A: Completed by Primary Care Provider

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

_____

_____

_____

_____

_____

_____

The patient is taking the following medication(s). (List all, including over the counter (OTC))

_____

_____

_____

_____

_____

_____

Prescriber Name _____

Please describe any special concerns (i.e., include abnormal lab results).

_____

_____

_____

PCP Name _____

Address _____

Phone _____

Date form completed _____

Section B: Completed by Behavioral Health Provider

The patient is being treated for the following behavioral health problem(s) and/or diagnoses (list all).

_____

_____

_____

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_____

_____

The patient is taking the following medication(s) (List all, including over the counter (OTC))

_____

_____

_____

_____

_____

_____

Prescriber Name _____

Please describe any special concerns (i.e., include abnormal lab results).

_____

_____

_____

BH Provider Name _____

Address _____

Phone _____

Date form completed _____