Behavioral Health Provider/Primary Care Provider Communication Form

The Member below is currently receiving services and has consented to share the following information between his/her PCP and BH provider.

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

Member name: _____ DOB: _____ Member ID#: _____

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 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 prescribed and OTC medications, with dosage and frequency as applicable)

_____ _____

_____ _____

_____ _____

Prescriber: _____

3. The patient has the following substance abuse problem(s) (if applicable):

_____

_____

_____

4. Please describe any special concerns:

_____

_____

_____

_____

Behavioral Health Clinician: _____

Behavioral Health Clinician Signature: _____

Provider Name/Site Name: _____

Address: _____

_____

_____

Phone: _____

Fax: _____

Date this form completed:

Section B: ***(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 prescribed and OTC medications, with dosage and frequency as applicable)

_____ _____

_____ _____

_____ _____

3. The patient has the following BH (MH/SA) problem(s) (if applicable):

_____

_____

_____

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

_____

_____

_____

_____

Primary Care Provider: _____

Primary Care Provider Signature: _____

Provider Name/Site Name: _____

Address: _____

_____

_____

Phone: _____

Fax: _____

Date this form completed: