# PCP Communication Form

Date: _____

Patient Name _____ SS#: _____

Date of Birth:_____ Health Plan: _____ Date of First Visit: _____

Primary MD: _____ Fax: _____

Dear Doctor: _____

The above patient of yours was recently referred by **Cenpatico** for mental health services. We hope that the following information will be helpful in coordinating our care.

**Type of Referral:** Routine Referral Urgent Referral Emergent Referral Post-hospitalization

| Type of Service | Check if Planned | Clinician Name |
|---|---|---|
| Group Therapy | | |
| Medication Management | | |
| Individual Therapy | | |
| Family Therapy | | |
| Other: | | |
| Referral for: | | |

**PSYCHIATRIST**

( ) The above named patient has been evaluated by me and was stated on a trial of:

| Medication | Dose | Schedule | Start Date | Change Date | Refill Due |
|---|---|---|---|---|---|
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |

( )The following information is being provided for coordination of care:

Follow-up appointment due: _____

Sincerely:

_____

(Clinician printed name/ initial)