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)