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Primary Care Provider (PCP) Communication Form

The patient listed below is currently receiving behavioral health services and has consented to share the following information with their PCP. In an effort to increase communication and promote coordination of care between providers, we ask that you review the behavioral health information and outreach to behavioral health provider to share relevant physical health information.

COORDINATION OF CARE FORM
(Please write clearly)

Patient Name____ Patient Date of Birth ____________________

Behavioral Health Provider Information
Name: ____
Phone: ____
Address: ____
Fax: ____

The Patient is being treated for the following problems:

- ☐ Mental Health Diagnosis ____
- ☐ Chronic Illness
- ☐ Medication Management
- ☐ Routine Care
- ☐ Substance Abuse
- ☐ Eating Disorder
- ☐ Other____

Treatment Start Date____________________ Date of Last Appointment________________

Medication and Dosages
1:
2:
3:
4:

Significant information that may impact medical or behavioral health treatment*:

____
____
____

**If you would like to discuss this member's treatment please contact me at the number above or fax pertinent information to the fax number above.*

____ ________________________________
Practitioner Signature Date