

## PCP Communication Form

Date: \_\_\_\_\_

Member Name \_\_\_\_\_ SS#: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Health Plan: \_\_\_\_\_ Date of First Visit: \_\_\_\_\_

PCP: \_\_\_\_\_ Fax: \_\_\_\_\_

Dear Doctor: \_\_\_\_\_

The person identified above was recently referred to **Cenpatico** for behavioral health services. The following information is provided for coordination and continuity of care purposes.

**Type of Referral:**                      Routine                      Urgent                      Emergent

Type of Service	Check if Planned	Clinician Name
Individual Therapy		
Family Therapy		
Group Therapy		
Medication Management		
Other:		
Provide explanation for other here		

**Diagnosis: Provide all behavioral health diagnoses**  
**Current Labs Ordered: Attach all current lab values**

Medication	Dose	Schedule	Start Date	Change Date	Refill Due

Next Schedule Appointment: \_\_\_\_\_

Sincerely:

\_\_\_\_\_  
(Clinician printed name/ initial)

**Provide behavioral health clinician contact information for receipt of PCP responses to communication.**