



## Primary Care Physician to Behavioral Health Provider Communication Form

Date: \_\_\_\_\_ Patient Medical Insurance ID Number: \_\_\_\_\_

Patient Name: \_\_\_\_\_ Patient Date of Birth: \_\_\_\_\_

Allergies (if applicable): \_\_\_\_\_

\_\_\_\_\_

### Relevant Past and Present Medication Use

<i>Name of Medication</i>	<i>Dosage</i>	<i>Frequency</i>	<i>Date Initiated/Discontinued</i>

Any adverse reactions to listed medications? \_\_\_\_\_

\_\_\_\_\_

Relevant Past and Present Medical Conditions: \_\_\_\_\_

\_\_\_\_\_

Current Abnormal Lab Values (may attach separate copies of lab results sheets if preferred and include any Thyroid and Liver Function tests): \_\_\_\_\_

\_\_\_\_\_

Primary Care Physician Name: \_\_\_\_\_

Primary Care Practice Site and ID Number: \_\_\_\_\_

Primary Care Physician Phone Number: \_\_\_\_\_

Primary Care Physician Fax Number: \_\_\_\_\_

Signature of Person Completing Form: \_\_\_\_\_

Current signed member release of information authorization form?

\_\_\_\_ Yes \_\_\_\_ No; Date of Expiration \_\_\_\_\_