Primary Care Physician to Behavioral Health Practitioner Communication Form

Date: ____________________ Patient Medical Insurance ID Number: ________________

Patient Name: ____________________________ Patient Date of Birth: _________________

Reason for Referral (if applicable): ____

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Allergies: ____

Relevant Past and Present Medication Use

Name of Medication	*Dosage*	*Frequency*	*Date Initiated/Discontinued*

Any adverse reactions to listed medications? _______________________________________

Relevant Past and Present Medical Conditions: ______________________________________

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Current *Abnormal* Lab Values (may attach separate copy of lab results sheets if preferred) (Include any Thyroid and Liver Function tests): ________________________________

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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:

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****Current signed member release of information authorization form?: _____yes ____no;**
Date of Expiration____________

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