Independence

PCP to Behavioral Health Provider Communication Form

Date: _____ Patient medical insurance ID #: _____

Patient name: _____ Patient date of birth: _____

Reason for referral (if applicable): _____

Allergies (if applicable): _____

_____

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: _____

_____

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 (PCP) name: _____

PCP site and ID #: _____

PCP telephone #: _____

PCP fax #: _____

Current, signed *Authorization to Release Information* form? ❑ Yes ❑ No Expiration: _____

Signature of person completing form: _____