AmeriHealth

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

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 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 _____