



**Primary Care Physician to Behavioral Health Provider
Communication Form**

Date: _____ Patient Medical Insurance ID Number: _____

Patient Name: _____ Patient Date of Birth: _____

Reason for Referral (if applicable): _____

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 _____