Behavioral Health Practitioner or Facility to Primary Care Physician Communication Form

Participant name ______ Participant ID # ______ Participant date of birth ______

To
Contact: ______________________
Phone: ______________________
Fax: ______________________
Release of Information Obtained (circle one): Yes No

From
Contact: ______________________
Phone: ______________________
Fax: ______________________
Address: ______________________
____

Date admission or treatment began: ______________ Date facility discharge or last seen: ______________

Behavioral diagnosis or condition (note if "initial" or "final")	
Mental health or substance use:	
Treatment recommendations (note if "planned" or "completed")	
Ancillary tests / evaluations / findings:	
Behavioral prescriptions and dosages:	
Outcome of treatment	
Degree of problem resolution:	Indications for re-referral:
Discharge medications:	Follow-up recommendations:
Clinical issues (e.g. compliance, stability, medication issues, co-morbid conditions):	

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