Primary Care Provider Behavioral Health Communication Form

Reviewed by PCP (signature): _____

Member's Health Plan	NHPRI	UBH	Date:

Attention Behavioral Health Provider _____. The patient lis~~ted below is currently re~~ceiving services and has consented to share the following medical information in Section B. Please complete the information in Section A.

Member Name: _____ DOB: _____ Insurance ID#: _____

SECTION A
1. Attached is a signed copy of the release of information (please one): Y N
2. The patient is being treated for the following behavioral health problem(s): LIST ALL DIAGNONES
3. The patient is taking the following prescribed psychotropic medication(s): (List ALL MEDICATIONS AND DOSAGE)
4. The patient has the following Substance Abuse issue (if applicable):
5. Please describe any special concerns:
Psychopharmacologist, is applicable:
Behavioral Health Clinician:
Behavioral Health Clinican Signature:
Address:
Phone:
Fax:

SECTION B
PCP: Please complete and return to the above behavioral health provider via mail or fax
1. Attached is a copy of patient's last physical with date of last appointment (please circle): Y N
2. The patient is being treated for the following medical problem(s): (LIST ALL DIAGNOSES)
3. The patient is taking the following prescribed medication(s):
4. The patient has the following Substance Abuse Issue (If applicable):
5. Please describe any special concerns:
PCP Completing communication form:
Primary Care Physician Signature:
Address:
Phone: