# PRIMARY CARE PHYSICIAN (PCP)/ BEHAVIORAL HEALTH (BH) PROVIDER COMMUNICATION FORM

**In an effort to increase communication and promote care coordination between providers, we ask that you please review and complete the following information.**

Patient Name: _____ DOB: _____

A signed copy of the release of information (ROI) must be attached to this form.

Indicate date of expiration of ROI: _____

## Section A: Completed by PCP

1. The patient is being treated for the following medical problem(s) and/or diagnoses *(list all)*:

_____ _____

_____ _____

_____ _____

2. The patient is taking the following medication(s) *(list all)*, including over-the-counter:

_____ _____

_____ _____

_____ _____

Prescriber: _____

3. Please describe any special concerns *(i.e. include abnormal lab results)*:

_____

_____

_____

PCP: _____

Address: _____

Phone: _____

Date this form completed: _____

## Section B: Completed by BH Provider

1. The patient is being treated for the following BH problem(s) and/or diagnoses *(list all)*:

_____ _____

_____ _____

_____ _____

2. The patient is taking the following medication(s) *(list all)*, including over-the-counter:

_____ _____

_____ _____

_____ _____

Prescriber: _____

3. Please describe any special concerns *(i.e. include abnormal lab results)*:

_____

_____

_____

BH Provider: _____

Address: _____

Phone: _____

Date this form completed: _____



25-775 (8/25)

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