

CONFIDENTIAL
REPORT TO PRIMARY CARE PHYSICIAN FROM MENTAL HEALTH PROVIDER
TO BE SENT WITHIN 7 DAYS OF VISIT

The patient named below has consented to allow me to communicate with you about their treatment. Please see attached copy of the consent form signed by the member.

Patient: _____ **Member # :** _____

DOB: _____ **Date(s) Patient Seen:** _____

Dear Dr. _____

This letter is sent so that your records can reflect the current mental health treatment this patient is receiving from me. To help in the collaborative management of this patient, *please complete the information* at the bottom of this sheet and mail or fax it back to me.

Patient Diagnosis: Axis I _____ **Axis II** _____ **Axis III** _____ **Axis IV** _____ **Axis V** _____

NOTE: PLEASE WRITE OUT THE DIAGNOSIS AS PCPS ARE UNFAMILIAR WITH DSM IV

Special Precautions (potential risk of harm to self or others): _____

Psychotropic medications prescribed and by whom: _____

Stress related factors are: family; work; school; legal; death; divorce; financial; loss of significant other; social; spiritual; marital; other _____

Frequency of Treatment: _____

Severity of problem: none to minimal; mild; moderate; severe; very severe/crisis state

Treatment recommendations/ plans at this time include: _____

Sincerely,

Signature and Credentials

Date

Name (print): _____ **Specialty/Discipline:** _____

Address: _____

Phone: _____

Fax: _____

.....
PCP-Please complete and return via mail or fax to the Behavioral Healthcare Provider

Date of last complete physical exam: _____

Any significant abnormal findings or lab values: _____

Current medications you have prescribed or are aware that the patient is taking:

Current concerns/ issues of which you should be aware:

PCP Signature and Credentials

Date