

COMMUNICATION DOCUMENT FOR BEHAVIORAL HEALTH SPECIALIST TO PRIMARY CARE PHYSICIAN

FROM: Behavioral Health Specialist:	Telephone #:
TO: Primary Care Physician/Address:	
RE: Patient Name:	Birthdate: Policy Holder's SS#:

CLINICAL INFORMATION

Date(s) of Initial Evaluation or Most Recent Treatment: _____

Current Symptoms/Complaints: _____

DSM-IV Descriptive Diagnoses:
Axis I (Primary Psych. Diagnoses): _____ Axis II (Personality Disorder/MR): _____

Axis III (Relevant Medical Conditions): _____ Axis IV (Social/Family Factors): _____

Treatment Plan Recommended to Patient: **Type:**

- Individual Therapy
- Family/Couples
- Group Therapy
- Addictions Program/Rehab
- Other: _____

Frequency: _____

Behavioral Health Medications Prescribed:

<u>Type:</u>	<u>Dosage/Frequency:</u>	<u>Date Initiated/Changed</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Results of Psychological Testing/Laboratory Orders: _____

Comments (Patient's response, treatment compliance, patient education, etc): _____

Behavioral Health Specialist Signature/Title: _____ Date: _____