

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:

Type:

Dosage/Frequency:

Date Initiated/Changed

Results of Psychological Testing/Laboratory Orders: _____

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

Behavioral Health Specialist Signature/Title:

Date: