Primary Care Provider Communication Form

Patient's Name: ______________________________ ID #: ____________________

Date of Birth: ______________________________

Primary MD: ______________________________

Dear Doctor:

The above patient of yours was recently referred to Access Behavioral Care. We hope that the following information will be helpful in coordinating behavioral and medical health care for this patient.

Date of Evaluation: ______________________________

DSM-IV Diagnosis:

Axis I:

Axis II:

Axis III:

Axis IV:

Axis V:

TREATMENT PLAN:

Individual Psychotherapy ________ x/week ________ x/month

Family Therapy ________ x/week ________ x/month

Group Therapy ________ x/week ________ x/month

Other: ______________________________

Medications: ______________________________

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Patient Education/Instructions: ______________________________

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Additionally: ______________________________

______________________________ ____________________

Therapist: ______________________________ Telephone #: ____________________

Psychiatrist: ______________________________ Telephone #: ____________________

Please call if further information would be helpful.

Sincerely,

cc:
ABC Client Record
Physician