

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: _____

Patient Education/Instructions: _____

Additionally: _____

Therapist: _____ Telephone #: _____

Psychiatrist: _____ Telephone #: _____

Please call if further information would be helpful.

Sincerely,