

PCP Communication Form

Date: _____

Patient Name: _____ SS #: _____

Date of Birth: ____ / ____ / ____ Health Plan: _____ Date of First Visit: _____

Primary M.D.: _____ Fax Number: _____

Dear Doctor: _____

The above patient of yours was recently referred by **Cenpatico Behavioral Health (CBH)** for mental health services. We hope that the following information will be helpful in coordinating our care.

Type of Referral: Routine Referral Urgent Referral Emergent Referral
 Post-hospitalization

Type of Service	Check if Planned	Clinician Name
Group Therapy		
Medication Management		
Individual Therapy		
Family Therapy		
Other:		
Referral for:		

PSYCHIATRIST

<p>() The above name patient has been evaluated by me and was started on a trial of:</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>(Medication/Dose/Schedule)</p> <p>_____ (Started/Change Date), _____ (Refill Due)</p>
<p>() The following information is being provided for coordination of care:</p> <p>Follow-up appointment due: _____.</p>

Sincerely:

 (Clinician printed name)

_____ MD PhD LCSW MFT
 (initial)