

# Behavioral Healthcare Practitioner and PCP Communication Form

This is a recommended format for the purpose of continuity and coordination of care.  
The form should be sent only after the treating practitioner obtains the appropriate signed member consent for the release of information.

## To be completed by the PsychCare practitioner's office

Patient name \_\_\_\_\_ Practitioner name \_\_\_\_\_  
 Member ID number \_\_\_\_\_ Phone \_\_\_\_\_  
 PCP name \_\_\_\_\_ Fax \_\_\_\_\_  
 PCP Phone \_\_\_\_\_ Diagnosis: Axis 1 \_\_\_\_\_  
 PCP Fax \_\_\_\_\_ Axis II \_\_\_\_\_  
 Pharmacy Phone \_\_\_\_\_ Axis III \_\_\_\_\_

## Section 1 to be completed by psychiatrist

Date	Medication	Dosage	Directions	Qty./Refills
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

Date	Medication	Most recent level
_____	_____	_____
_____	_____	_____

Significant information \_\_\_\_\_  
 \_\_\_\_\_

Psychiatrist signature \_\_\_\_\_ Date / /

## Section 1 to be completed by PCP

Date	Medication	Dosage	Directions	Qty./Refills
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

Date	Medication	Most recent level
_____	_____	_____
_____	_____	_____

Significant information \_\_\_\_\_  
 \_\_\_\_\_

Psychiatrist signature \_\_\_\_\_ Date / /

