home state health™

Primary Care Provider (PCP) Communication Form

The patient listed below is currently receiving behavioral health services and has consented to share the following information with their PCP. In an effort to increase communication and promote coordination of care between providers, we ask that you review the behavioral health information and outreach to behavioral health provider to share relevant physical health information.

COORDINATION OF CARE FORM
(Please write clearly)

Patient Name_____ Patient Date of Birth _____

Behavioral Health Provider Information
Name: _____
Phone: _____
Address: _____
Fax: _____

The Patient is being treated for the following problems:

- ☐ Mental Health Diagnosis _____
- ☐ Chronic Illness
- ☐ Medication Management
- ☐ Routine Care
- ☐ Substance Abuse
- ☐ Eating Disorder
- ☐ Other_____

Treatment Start Date_____ Date of Last Appointment_____

Medication and Dosages
1:
2:
3:
4:

Significant information that may impact medical or behavioral health treatment*:
_____
_____
_____

**If you would like to discuss this member's treatment please contact me at the number above or fax pertinent information to the fax number above.*

_____ _____
Practitioner Signature Date