Behavioral Health Services Primary Care



Information Sharing Form (Revised 11/2012) @Practice: ___ To Physician: ____

Date:	Initial ReferralFollow-Up
Referring Agency:	
Clinician:	Case Manager:
Fax: ()	Phone: ()
Patient Name:	DOB:
Parent/Guardian Name	DOB: Phone: ()
Date(s) Patient Seen:	
Parent/Guardian Name: Date(s) Patient Seen: Current Services to Patient: Missing appointments frequently0. Not benefitting from appointments0. Current Diagnoses:	
Current services to Fatient:	
•	
<u> </u>	
 Missing appointments frequently0. 	12345Attending all appointments
 Not benefitting from appointments0. 	12345Highly benefitting
Current Diagnoses:	
{	
•	
Current Medications Prescribed:	Prescribed by:
•	
Key Exacerbating Factors (family history, beha	
Kev Exacerbating Factors (family history, behavior)	avioral triggers, ongoing triggers, life changing events, etc.):
·	
Relevant Lab Results: Provided by Behavioral Health: Crisis plan is attached Individual / Group / Family / In-home thera	
Relevant Lab Results:	
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Provided by Behavioral Health:	Needed from Primary Care:
☐ Crisis plan is attached	No reply needed at this time
☐ Individual / Group / Family / In-home thera	
Clinical Assessment (psychological/ psychological/	osexual/ Referrals recommended
	Sexual/ Referrals recommended
neuropsych/ substance abuse)	Lab tests (freq.)
☐ Medication management	Reinforce service benefits to patient/family
☐ Lab tests (frequency)	□ Other
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