AVMED PRIMARY CARE PHYSICIAN (PCP)/BEHAVIORAL HEALTH

Provider Communication Form

Note: This is a ***recommended*** format for the purpose of continuity and coordination of care. The form should be sent ***only*** after the treating Primary Care Physician (PCP) obtains the appropriate signed member consent for release of information.

Patient Information:

Patient Name _____ Date of Birth _____

Health Plan _____ ID Number _____

BH Provider Name _____ BH Provider Fax Number _____

PCP Information:

PCP Name _____ PCP Office Number _____

Medical Data:

Diagnosis	Prescribed Medications and Dosages
Primary Dx:	
Secondary Dx:	
Additional Dx:	

Follow-Up Information:

Patient is currently being monitored for the following lab values:

Blood Glucose ☐ Cholesterol ☐ Triglycerides ☐ Other _____

Date of Last Visit _____ Date of Anticipated Next Visit _____

Significant Information:

_____

_____

_____

PCP Signature _____ Date _____