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 ____________________