CONTINUITY OF CARE CONSULTATION SHEET

This form is provided to facilitate communication between behavioral health and primary care physicians to enhance continuity and coordination of care. Please complete the information below and forward to the appropriate practitioner.

MEMBER INFORMATION	
Member Name:	
Date of Birth:	ID #:

BEHAVIORAL HEALTH	PRIMARY CARE PROVIDER
Provider Name:	Provider Name:
Provider ID/NPI:	Provider ID/NPI:
Provider Phone Number:	Provider Phone Number:

TREATMENT UPDATES
Date/Reason for Behavioral Health visit: *(check one)*:
☐ Initial Evaluation ☐ Continuation of Treatment ☐ Re-evaluation ☐ Crisis ☐ Testing
Date/Reason for PCP visit:
Diagnosis:

CURRENT MEDICATION LIST: *(Please include long-term and newly prescribed medications)*

RECOMMENDATIONS FOR CONTINUED TREATMENT REGIMEN:

Please feel free to contact the office with any questions and/or concerns. **Do not forget to download and sign the Authorization to Disclose Health Information to PCP Form from our website**. Thank you.

Name of Person Completing Form:	
Provider Name:	Date:

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