POLICY FORM 902.1
COMMUNICATION DOCUMENT

Print Form | Submit by Email

To: (Primary Care Provider Name): Phone #

From: Clinician Name: Clinician Phone:

T/RBHA Name:

Dear Primary Care Provider:

We are sending this information to you for coordination of care. We believe you are the assigned care provider for this patient, although you may not have seen this patient yet. If you would like to have more information, or need to discuss this patient, please contact the behavioral health care provider listed.

Patient Name:

Patient Date of Birth:

AHCCCS ID#:

Medicare ID#:

I. CLINICAL SUMMARY

1) DSM V Diagnoses (required):

Medications

2) Summary of critical labs:

☐ Behavioral Health Assessment (Date):

☐ Results of non-critical laboratory, radiology or other tests (Date):

☐ Other (Please specify):

II. ADDITIONAL BEHAVIORAL HEALTH PROVIDER CONTACT INFORMATION

Psychiatrist, Nurse Practitioner, Physician Assistant Name:

Psychiatrist, Nurse Practitioner, Physician Assistant Phone #:

Case Manager: Phone #:

Other Contact Name: Phone #:

☐ Mailed ☐ Faxed Sender name: Date:

Signature of clinician completing form: Date:

Note: This form must be completed in its entirety to demonstrate appropriate communication to the PCP. Retain copy in person's comprehensive clinical record.