

There must be Consent Form with communication with PCP

PRIMARY CARE PROVIDER/ BEHAVIORAL HEALTH COMMUNICATION FORM

Patient First Name:	Patient Last Name:	Patient DOB:
Patient's Health Plan:	Insurance ID #:	Date:

ATTENTION PCP: The patient listed below is currently receiving behavioral health services and has consented to share the following information with their PCP. In an effort to increase communication and promote care coordination between providers, we ask that you review the behavioral health information in Section A. Please complete the medical information in Section B.

Section A. Please attach a signed copy of the information release form.

- (ICD-10/DSM-5)
- Diagnosis 1:
 - Diagnosis 2:
 - Diagnosis 3:
 - Diagnosis 4:

Current Medication (Dosage, Frequency):

1. Current Treatment & Expected Duration (Modalities, Frequency):
2. Behavioral Health Clinician:
3. Psychopharmacologies (if applicable):

Program services: <input type="radio"/> Outpatient <input type="radio"/> Substance Abuse/ case management services <input type="radio"/> Recovery Coaching <input type="radio"/> Recovery Support Navigation <input type="radio"/> Applied Behavior Analysis In Home Behavioral <input type="radio"/> In Home Therapy <input type="radio"/> Therapeutic Mentoring <input type="radio"/> Adult Day Health or Adult Foster Care /Group Foster Care	44 DIAUTO Drive Randolph Ma 02368	Phone:781 8857252 Fax: 781 885 7256
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LAMOUR CLINIC	44 DIAUTO Dr Randolph Ma 02368	Phone:781 8857252 Fax: 781 885 7256
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Section B. PCP: PLEASE CONTACT THE ABOVE BEHAVIORAL HEALTH PROVIDER VIA PHONE OR Fax WITH THE FOLLOWING INFORMATION:

Program services referral letter for: <input type="radio"/> Applied Behavior Analysis or In Home Behavioral <input type="radio"/> Adult Day Health or Adult Foster Care /Group Foster Care <input type="radio"/> Home and Community Based Services <input type="radio"/> Physical Therapy <input type="radio"/> Speech Therapy <input type="radio"/> Other ____	Medical Information (i.e. medication, medical concerns): with Copy of patient's last physical <input type="radio"/> Next date of Appointment	Fax to: 781 885 7256 Or Email to: Intake@lamourclinic.org
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