There must be Consent Form with communication with PCP

PRIMARY CARE PROVIDER/ BEHAVIORAL HEALTH COMMUNICATION FORM

Patient Frist 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: ○ **Outpatient** ○ **In Home Behavioral** ○ **In Home Therapy** ○ **Therapeutic Mentoring** ○ **Community Support Programming**	**44 DIAUTO Drive** **Randolph Ma 02368**	**Phone:781 8857252** **Fax: 781 885 7256**

LCHI CLINIC	**42 DIAUTO Dr Randolph Ma 02368**	**Phone:781 8857252** **Fax: 781 885 7256**

Section B. PCP: PLEASE CONTACT THE ABOVE BEHAVIORAL HEALTH PROVIDER VIA PHONE OR Fax WITH THE FOLLOWING INFORMATION:

Program services referral letter for: ○ **Outpatient** ○ **In Home Behavioral** ○ **In Home Therapy** ○ **Therapeutic Mentoring** ○ **Community Support Programming** ○ **Other ____**	**Medical Information (i.e. medication, medical concerns): with Copy of patient's last physical** ○ **Next date of Appointment**	**Fax to:** **781 885 7256** **Or** **Email to:** **Intake@LCHIclinic.org**