PHYSICAL AND BEHAVIORAL HEALTH COORDINATION OF CARE INFORMATION

Date: _____
To: _____
Re: _____ Client's Date of Birth: _____

Dear Dr. :
I am currently providing mental health treatment to this client. This client was enrolled for treatment on _____ and has designated you as his/her primary care physician. A release of information was signed. We have encouraged him/her to maintain ongoing medical care with you. We wish to keep you informed of pertinent information related to his/her mental health treatment.
Primary DSM-V/ICD-10 Diagnosis:
Primary: _____
Secondary: _____

Current medications (as reported by client):_____
_____
_____

Additional Comments:
_____
_____
_____
_____

PLEASE BE AWARE THAT THE ABOVE INFORMATION WAS ACCURATE AS OF THE TIME THIS LETTER WAS SENT. IN THE COURSE OF TREATMENT, CHANGES MAY OCCUR.

Behavioral Health Provider Name _____
Fax# ___-___-_____
Office Location _____
Phone# ___-___-_____

TO FACILITATE COORDINATION OF CARE, PLEASE SEND US RELEVANT INFORMATION REGARDING THIS CLIENT'S MEDICAL TREATMENT, INCLUDING ANY ICD-9 MEDICAL DIAGNOSES, MEDICATIONS PRESCRIBED AND ANY ABNORMAL LAB RESULTS, AS APPROPRIATE.

Also, please indicate additional correspondence you would like to receive (optional):
( ) Notice of a Psychiatric Hospitalization ( ) Behavioral Health Treatment Plan Information
( ) Notice of an Emergency Room Visit

Sincerely,

Primary Therapist/Clinician
Original to: PCP, Copy to: Chart

NAME: MEDICAID ID#: DATE: