Outpatient Mental Health Visit Summary

To be completed by treating psychiatrist or therapist and sent to health care providers noted below, as authorized on Release of Information form.

Patient Last Name ____________ Patient First Name ____________ Patient Middle Name ____________ Birthdate ____________

Parent(s)/Guardian(s) Name (if pt is < 18 y) ____________

Patient Tel #s: (Home/Cell/Work) ____________ ____________ ____________

Provider and Facility providing mental health care ____________

Visit Date(s) ____________

Diagnoses

Axis I: ____________

Axis II: ____________

Axis III: ____________

Medications ____________

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Follow up appointments

PCP Name	Appt date	or suggested interval until appt
Psychiatrist Name	Appt date	or suggested interval until appt
Psychotherapist Name	Appt date	or suggested interval until appt

Other comments or recommendations for PCP or other staff (specify):

Information on this form communicated in secure fashion as follows:

❒ PCP	❒ Discussed directly	❒ Voice mail (tel #): ____________	❒ Faxed (#): ____________
❒ Psychiatrist	❒ Discussed directly	❒ Voice mail (tel #): ____________	❒ Faxed (#): ____________
❒ Psychotherapist	❒ Discussed directly	❒ Voice mail (tel #): ____________	❒ Faxed (#): ____________
❒ School Staff	❒ Discussed directly	❒ Voice mail (tel #): ____________	❒ Faxed (#): ____________

Form Completed by Mental Health Provider:

Name ____________ Specialty ____________ Tel # ____________ Fax # ____________