ADDRESSING
Mental Health
CONCERNS IN
PRIMARY CARE
A CLINICIAN'S TOOLKIT

Medical Record No. or Stamp

Primary Care Referral and Feedback Form

Date: ________________ **( ) Initial** **( ) Follow-up**

Referring Physician Name: ______________________________

Address: ______________________________
(Street/PO Box) **City** **State** **Zip**

Fax: (____) ______________ **Phone:** (_____) ______________

Patient's Name: ______________ **DOB:** ______________

Parent's Name: ______________ **Address:** ______________ **Phone:** ______________

Date(s) Patient Seen: ______________________________

Reason(s) for Referral: ______________________________

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____

Any Specific Questions or Requests: ______________________________

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____
Referring Physician's Printed Name/Signature

Thank you for evaluating this patient. To facilitate communication and treatment, please make copies of the following form to retain in the patient's record; complete a form after initial assessment; complete additional forms periodically during treatment (as indicated) and when treatment is terminated; and mail or fax completed form(s) to the physician listed above. This is not a request for copies of psychotherapy notes, which require a signed consent to release. Thank you for your collaboration.

Consultant's Report

Date(s) Patient Seen: ______________________________

- ❑ Patient did not make appointment.
- ❑ Patient made an appointment but did not keep appointment.
- ❑ Patient not seen within 60 days.

Initial Diagnoses:

1. ______________________________
2. ______________________________
3. ______________________________

Recommendations: ______________________________

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Medications Prescribed: ______________________________

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Follow-up Arranged or Provided by Consultant:

- ❑ Further diagnostic testing ________________
- ❑ Individual therapy
- ❑ Group therapy
- ❑ Family therapy
- ❑ Lab tests
- ❑ Medication management
- ❑ Return visit ______

Other Care Needed:

- ❑ Medication management by PCC
- ❑ Referrals recommended ______________
- ❑ Follow-up recommended ______________
- ❑ Other: ________________

____
Name (type or print) **Signature**

FAX to ______________________________
\# ***contact person***

*Add disclaimer statement per your institution here:*______________________________

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