

# Primary Care And Behavioral Health Services Information Sharing Form

Suggested Use for Improved Collaboration (Revised 10/2014)

Primary Care – Complete this Section

Date: \_\_\_\_\_ Initial Referral:  Follow-Up:   
Physician: \_\_\_\_\_ Practice: \_\_\_\_\_  
Fax: (\_\_\_\_) \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_  
Patient's Name: \_\_\_\_\_ DOB: \_\_\_\_\_  
Parent/Guardian Name: \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_  
Carolina Access Referral NPI #: \_\_\_\_\_  
Current Medical Diagnoses:  
 Are Attached  
 Listed here: \_\_\_\_\_  
Current Medications Prescribed:  
 Are Attached  
 Listed here: \_\_\_\_\_  
Known Allergies:  
 Are Attached  
 Listed here: \_\_\_\_\_  
Reason for Referral (*family history, behavioral triggers, ongoing triggers, life changing events, etc.*):  
 Are Attached  
 Listed here: \_\_\_\_\_  
 Release of information is signed by patient and attached  
What did you tell the patient is the reason for the referral? \_\_\_\_\_  
Initial Services Requested from Behavioral Health:  
 Comprehensive Clinical Assessment (CCA) – is mandatory at initial visit  
 Medication Evaluation – (is not offered as a “stand alone” service)  
Behavioral Health Records requested:  
 Medication List  
 Person Centered Treatment Plan  
 Recent Lab results (if any)  
 Other \_\_\_\_\_

Behavioral Health Services – Complete this Section

## Behavioral Health Services Feedback

- Patient has NOT been seen for services.
- Initial assessment is scheduled for (date) \_\_\_\_\_. Follow-up will be faxed after patient appointment.

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Agency: \_\_\_\_\_ Case Responsible: \_\_\_\_\_  
Fax: (\_\_\_\_) \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_  
Date(s) Patient Seen: \_\_\_\_\_  
Current Services Are Recommended for Consumer:  
 Basic Outpatient therapy (Individual, Family, Group)  
 Medication Management  
 Enhanced Services (ACTT, CST, PSR, SAIOP, IIH, Day Treatment)  
• Missing appointments frequently ....0.....1.....2.....3.....4.....5...Attending all appointments  
• Not benefitting from appointments..0.....1.....2.....3.....4.....5...Highly benefitting  
The following behavioral health information is attached:  
 Release of Information  
 Diagnosis: Axis I and Axis II  
 Current Clinical Issues  
 Medication List  
 Recent lab work  
 Pain Contract  
 Crisis Plan  
 Other: \_\_\_\_\_  
Primary Care: Please fax the following Medical Information to Behavioral Health Provider (see contact information above).  
 Most Recent Physical Exam  
 Updated Problem/Medical Diagnosis  
 Medication List  
 Recent Lab Work  
 Pain Contract (if applicable)  
 Other: \_\_\_\_\_