BEHAVIORAL HEALTH FEEDBACK TO PRIMARY CARE SECTION II

Referral back to Primary Care Provider/Practice: _____

Date: _____ MID:_____

Patient's name: _____ DOB: _____

Behavioral Health Agency: _____ Name of Contact: _____

Phone: _____ Fax: _____ Email: _____

Mark all that apply

- ☐ Patient did not schedule an appointment.
- ☐ Patient did not keep the scheduled appointment on _____
- ☐ Patient kept appointment on _____
- ☐ Behavioral Health Assessment was completed on _____
- ☐ Patient was seen, but refuses to give consent for sharing information at this time.
- ☐ Other: _____

Initial Diagnosis(es)/ Diagnostic Impression: (Axis I/ Axis II):

- ☐ Medications were prescribed by _____ and list is attached.
- ☐ Labs ordered _____
- ☐ Other information/documents attached _____

Follow up plan:

Patient**:**

- ☐ Declined behavioral health services.
- ☐ Was referred to another agency.

Agency name: _____ Phone: _____

- ☐ Agrees to continue behavioral health services with our agency.

Date of next appointment: _____Type of Service_____

- ☐ Medications to be managed by our agency.
- ☐ Medications to be managed by another provider.

Provider name: _____ Phone: _____

- ☐ Pain Agreement is recommended.
- ☐ Other:

Clinician completing this assessment: _____

Thank you for the opportunity to assess this patient

Developed by: Community Care of North Carolina