Blue Cross Blue Shield of Rhode Island

Primary Care/Behavioral Health Communication Form

PATIENT'S HEALTH PLAN: (Please circle) BCBSRI NHPRI UBH MEDICAID DATE: ____/____/____

ATTENTION Dr: _____. The patient listed below is currently receiving behavioral health services and has consented to share the following information with their PCP. In an effort to increase communication and promote care coordination between providers, we ask that you review the behavioral health information in Section A. Please complete the medical information in Section B.

Patient name: _____ DOB: ____/____/____ Insurance ID#: _____

SECTION A (to be completed by behavioral health provider)

1. Attached is a signed copy of the release of information: *(please circle)*

Y N

2. The patient is being treated for the following behavioral health problem(s): *(list all diagnoses)*

_____ _____

_____ _____

3. The patient is taking the following prescribed psychotropic medication(s): *(list all medications and dosage)*

_____ _____

_____ _____

4. The patient has the following substance abuse issue(s): *(if applicable)*

_____

_____

_____

5. Please describe any special concerns:

_____

_____

_____

Psychopharmacologist, if applicable: _____

BH clinician name: _____

Address: _____

State: _____ ZIP: _____

Phone: _____

Fax: _____

BH clinician signature: _____

SECTION B (to be completed by PCP)

PCP: Please complete and return to the behavioral health provider named in Section A via mail or fax

1. Attached is a copy of the notes from the patient's last visit with date of last appointment: *(please circle)*

Y N

2. The patient is being treated for the following medical problem(s): *(list all diagnoses)*

_____ _____

_____ _____

3. The patient is taking the following prescribed medication(s): list all medications and dosage:

_____ _____

_____ _____

_____ _____

_____ _____

4. The patient has the following substance abuse issue(s): *(if applicable)*

_____

_____

_____

5. Please describe any special concerns:

_____

_____

_____

PCP name completing form: _____

Address: _____

State: _____ ZIP: _____

Phone: _____

Fax: _____

PCP signature: _____