

Primary Care/Behavioral Health

Request for Treatment Update

Instructions: Please complete the following information regarding:

Patient Name: _____ Phone #: _____

Gender: _____ Date of Birth: _____

Please return the completed form by fax to:

Provider name: _____ Phone: _____ Fax: _____

Current complaint/brief assessment:

Diagnoses: _____

Is the patient pregnant or nursing: _____ Yes _____ No (check one)

Current Medications	Dosage	Frequency	Target behaviors/symptoms	Refills

Treatment Plan and Progress:

Significant changes in client's life situation (home, school, social):

Any known questions/concerns of patient or guardian:

Next appointment (Date/Time): _____

Primary care physician signature

Date