Referral for Primary Care Medication Management

NEW ◯ MODIFICATION ◯

BH Clinic: _____ *Phone:* _____ *Fax:* _____

Patient Name: _____ *Home Phone #:* _____

Gender: _____ *Date of Birth:* _____ *Date entered treatment:* _____

Parent/Legal Guardian (if applicable): _____

BH Clinic prescribing practitioner: _____ *Primary therapist (if other):* _____

Primary Care Physician: _____ *Phone:* _____ *Fax:* _____

Current complaint/brief assessment:

Diagnoses: _____ _____

_____ _____

Co-occurring medical conditions: _____

Was pregnancy test done? ◯ Yes ◯ No If so, when? _____

Current Medications	Dosage	Frequency	Target Behaviors/Symptoms	Refills

Previous medications:

Treatment and Medication Management Recommendations:

Suggested frequency for initial follow up appointments with PCP: _____

Suggested test/interval: EKG: _____ Labs: _____ Other: _____

BH Clinic therapist ◯ will not ◯ will continue therapy. Frequency _____ Next appt date: _____

_____ _____

Prescriber's Signature Date

PCP ◯ Agrees ◯ Rejects ◯ Needs further discussion regarding the referral.

PCP medication follow-up to be provided by: _____

If agreed, date and time of next appointment with PCP: _____

_____ _____

Primary care physician signature Date