



BEHAVIORAL HEALTH AGENCY REQUEST FOR INFORMATION

Date: _____

MID: _____

Patient's name: _____

DOB: _____

This patient is currently receiving Behavioral Health Services at our agency and lists your practice as his/her primary care provider.

- If this patient is no longer receiving services in your practice, please check this box and fax back to our agency.*

Agency name: _____

Address: _____

Phone: () _____ Fax: () _____ Email: _____

The following Behavioral Health Information is attached.

- Diagnosis(es): Axis I and Axis II
- Current Clinical Issues
- Medication List
- Recent Labwork
- Pain Contract
- Other _____

Please fax the following Medical Information to:

_____ **Fax number:** _____

(Name of Contact)

- Most Recent Physical Exam
- Medical Diagnosis(es)
- Medication list
- Recent lab work
- Pain Contract (if applicable)
- Other _____

Thank you,

Name of requesting provider (Psychiatrist, Physician Assistant, Nurse Practitioner, PhD, LCSW, LPC)