



BEHAVIORAL HEALTH FEEDBACK TO PRIMARY CARE

SECTION II

Date: _____ MID _____

Patient's name: _____ DOB: _____

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: _____

Assessment

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 Contract is recommended.
- Other:

Clinician completing this assessment: _____

Thank you for the opportunity to assess this patient