

# REPORT TO PRIMARY CARE PHYSICIAN FROM LICENSED MENTAL HEALTH PROVIDER

In accordance with federal statutes, this document has been authorized by the patient named below to allow me to communicate with you their diagnosis and treatment. This patient has identified you as their PCP and is aware of our efforts to coordinate their care.

Patient: \_\_\_\_\_ DOB: \_\_\_\_\_

Intake Date: \_\_\_\_\_ Next Visit Date: \_\_\_\_\_

Primary Care Physician: \_\_\_\_\_

## Diagnostic Information:

AXIS I: \_\_\_\_\_

AXIS II: \_\_\_\_\_

AXIS III: \_\_\_\_\_

AXIS IV: \_\_\_\_\_

AXIS V: \_\_\_\_\_

## Brief Treatment Plan:

\_\_\_\_\_  
\_\_\_\_\_

## Current Medication Concerns/Issues:

\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_ I understand that I have agreed to the release of information for collaborative care between my therapist at Coffee Counseling, Coaching, & Consulting (CCCC): Private Practice of Barbara Coffee, Ph.D., ABD, LMFT and the physician named above.

\_\_\_\_ I refuse consultation between my primary care physician and my therapist at CCC.

\_\_\_\_\_  
Patient/Patient's Representative Signature Date

\_\_\_\_\_  
Therapist Signature Date