

**BEHAVIORAL HEALTH  
CONSULTATION FOLLOW-UP**

DATE \_\_\_\_\_

PATIENT'S NAME \_\_\_\_\_ DATE OF BIRTH \_\_\_\_\_ HIP ID # \_\_\_\_\_

PRIMARY CARE PHYSICIAN (PCP) \_\_\_\_\_ PCP ADDRESS \_\_\_\_\_

- Mental Health**
- Substance Abuse**

Dear Dr. \_\_\_\_\_:

(Patient's name) \_\_\_\_\_ has been treated at the  
(Facility name) \_\_\_\_\_ by  
(Therapist's name) \_\_\_\_\_.

**THE FOLLOWING OUTCOMES HAVE TAKEN PLACE:**

- Treatment continues as per mutual agreement.
- Treatment was mutually terminated after goals were achieved.
- Patient did not follow up on recommended treatment despite outreach.
- Patient withdrew from recommended treatment voluntarily.
- Patient's care was transferred to the following facility:  
\_\_\_\_\_

Patient hospitalized at \_\_\_\_\_  
Dates hospitalized from: \_\_\_\_\_ to: \_\_\_\_\_

Patient currently on the following medication:  
1. \_\_\_\_\_  
2. \_\_\_\_\_  
3. \_\_\_\_\_  
4. \_\_\_\_\_

**Comments:** \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

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

**Please feel free to call if you need further information.**

**Clinician** \_\_\_\_\_ **Phone #** \_\_\_\_\_