

**BEHAVIORAL HEALTH
CONSULTATION**

DATE _____

PATIENT'S NAME _____

DATE OF BIRTH _____ HIP ID # _____

PRIMARY CARE PHYSICIAN (PCP) _____

PCP ADDRESS _____

SOURCE REFERRAL:

- Self
- PCP
- EAP _____
- Other _____

- Mental Health**
- Substance Abuse**

Dear Dr. _____:

(Patient's name) _____, under your care, has been evaluated at the
(Facility name) _____ on
(Date[s]) _____ by
(Therapist's name) _____.

THE FOLLOWING WAS RECOMMENDED:

- Patient to be treated by _____ Provider.
- No follow-up indicated.
- Patient referred back to PCP: _____

Patient hospitalized at _____ on _____

Medication evaluation by Dr. _____

Patient started on the following medication:

- 1. _____ 3. _____
- 2. _____ 4. _____

Patient declined treatment recommendation.

Patient has indicated concern about the following physical problems:

- 1. _____ 3. _____
- 2. _____ 4. _____

Comments and Diagnostic Impressions:

Signature _____

Date _____

Please feel free to call me at _____ if you need further information.