PCP Communication Form

Date: _____

Member Name _____ SS#: _____

Date of Birth:_____ Health Plan: _____ Date of First Visit:_____

PCP: _____ Fax: _____

Dear Doctor: _____

The person identified above was recently referred to IlliniCare Health for behavioral health services. The following information is provided for coordination and continuity of care purposes.

Type of Referral: ☐ Routine ☐ Urgent ☐ Emergent

Type of Service	Check if Planned	Clinician Name
Individual Therapy		
Family Therapy		
Group Therapy		
Medication Management		
Other:		
Provide explanation for other here		

Diagnosis: Provide all behavioral health diagnoses
Current Labs Ordered: Attach all current lab values

Medication	Dose	Schedule	Start Date	Change Date	Refill Due

Next Schedule Appointment: _____

Sincerely:

_____
(Clinician printed name/ initial)

Provide behavioral health clinician contact information for receipt of PCP responses to communication.