

**PM FORM 4.3.1
COMMUNICATION DOCUMENT**

To: (Primary Care Provider Name):
Address:

Phone #:
Fax #:

From: Clinician Name:
Provider Agency Address:
Provider Agency Fax #:

Provider Agency Name:
Provider Agency Phone #:
T/RBHA Name:

Dear Primary Care Provider:

We are sending this information to you for coordination of care. We believe you are the assigned care provider for this patient, although you may not have seen this patient yet. If you would like to have more information, or need to discuss this patient, please contact the behavioral health care provider listed.

Patient Name:
Patient Date of Birth:
Medicare ID#:

AHCCCS ID#:
AHCCCS Health Plan Name:
Medicare Advantage Plan Name:

I. REASON FOR THIS COMMUNICATION (Check applicable reasons)

- | | |
|---|---|
| <input type="checkbox"/> Patient referred by AHCCCS Health Plan/PCP/Medicare Provider | <input type="checkbox"/> Advance directive or refusal to sign |
| <input type="checkbox"/> Patient determined to be Seriously Mentally Ill (SMI) | <input type="checkbox"/> Significant change in diagnosis |
| <input type="checkbox"/> Information requested by AHCCCS Health Plan/PCP/Medicare Provider | |
| <input type="checkbox"/> Patient has Pervasive Development Disorder and/or Developmental Disability | |
| <input type="checkbox"/> Critical laboratory result | <input type="checkbox"/> Medication change |
| <input type="checkbox"/> Transferring care back to PCP | <input type="checkbox"/> Out of state placement |
| | <input type="checkbox"/> Annual notification |
| | <input type="checkbox"/> Other (please specify): |

II. CLINICAL SUMMARY

1) DSM-IV Diagnoses (required):
Axis I:
Axis II:
Axis III:

2) Dose, frequency and target symptoms of current behavioral health medications (required). (If transferring care back to PCP please indicate status of step therapy):

3) Summary of critical labs:

4) Other attached information (required only if requested by PCP, otherwise optional):

- Behavioral Health Assessment (Date):
- Individual Service Plan (Date):
- Results of non-critical laboratory, radiology or other tests (Date):
- Other (Please specify):

III. RESPONSE TO PCP'S REFERRAL QUESTION(S)

Date PCP referral from the Health Plan was received (if applicable):

IV. ADDITIONAL BEHAVIORAL HEALTH PROVIDER CONTACT INFORMATION

Psychiatrist, Nurse Practitioner, Physician Assistant Name:
Psychiatrist, Nurse Practitioner, Physician Assistant Phone #:
Clinical Liaison Name: Phone #:
Other Contact Name: Phone #:

Mailed Faxed Sender Name: _____ Date sent: _____

Signature of Clinician Completing Form: _____ Date: _____

Note: This form must be completed in its entirety to demonstrate appropriate communication to the PCP. Retain copy in person's comprehensive clinical record.