MCCMH SUBSTANCE USE DISORDER SERVICES
COMMUNICATION FORM TO PRIMARY CARE PHYSICIAN

Date:_____

To: _____
Primary Care Physician

_____
Address City State Zip

From: _____
Treatment Agency

_____
Therapist and Psychiatrist (if applicable)

_____
Address City State Zip

(___)_____ (___)_____ _____
Phone Number Fax Number Email Address

Re: _____ _____
Client Name Date of Birth

The above client was admitted to _____ on _____
Level of care Date

Treatment Plan: Type_____ Frequency_____ Est. length of Tx_____

Diagnosis:_____

Medication(s) Prescribed:_____
_____
_____

Comments:_____
_____
_____

Date of last session: _____ Treatment completed? Yes____No___

We ask that the Primary Care Physician please send information related to relevant medical history, current medications prescribed and treatment to the above psychiatrist/therapist.

Thank you for your assistance.

Date sent:_____ Initials of sender_____ Method: Fax__ Mail___Email__

cc: client chart