BEHAVIORAL HEALTH AGENCY REQUEST FOR INFORMATION

Date: _____ MID: _____

Patient's name: _____ DOB: _____

This patient is currently receiving Behavioral Health Services at our agency and identifies you/your practice _____as being their primary care provider.

☐ ***If this patient is no longer receiving services in your practice, please check this box and fax back to our agency.***

Requesting Agency name: _____

Address: _____

_____

Phone: _____ Fax: _____ Email:_____

Please fax the following Medical Information to:

_____ Fax number: _____

(Name of Contact)

- ☐ Most Recent Physical Exam
- ☐ Medical Diagnosis(es)
- ☐ Medication list
- ☐ Recent lab work
- ☐ Pain Agreement (if applicable)
- ☐ Other _____

Once we have confirmation that the above-named individual is your patient, we will share the following Behavioral Health Information.

- ☐ Diagnosis(es): Axis I and Axis II
- ☐ Current Clinical Issues
- ☐ Medication List
- ☐ Recent Lab work
- ☐ Pain Agreement (if applicable)
- ☐ Other _____

Thank you,

_____

Name of requesting provider/ credentials (Psychiatrist, Physician Assistant, Nurse Practitioner, PhD, LCSW, LPC, etc.)

Developed by: Community Care of North Carolina