PRIMARY CARE REFERRAL AND FEEDBACK FORM

Date: ____________ ( ) Initial ( ) Follow-up

Referring Physician Name: ________________________________

Address: ____________________________________________

(Street/PO Box) ______________________________________

City __________________ State ______ Zip ___________

Fax: ( ) __________________________ Phone: ( ) ___________

Patient’s Name: ___________________________ DOB: ___________

Parent’s Name: ___________________________ Address: ___________

Phone: __________________________

Date(s) Patient Seen:

Reason(s) for Referral:

Any Specific Questions or Requests ______________________________

__________________________

Referring Physician’s Printed Name/Signature

Thank you for evaluating this patient. To facilitate communication and treatment, please make copies of this form to retain in the patient’s record; complete a form after initial assessment; complete additional forms periodically during treatment (as indicated) and when treatment is terminated; and mail or fax completed form(s) to the physician listed above. This is not a request for copies of psychotherapy notes, which require a signed consent to release. Thank you for your collaboration.

Consultant’s Report

Date(s) Patient Seen:

☐ Patient did not make appointment.

☐ Patient made an appointment but did not keep appointment.

☐ Patient not seen within 60 days.

Initial Diagnoses:

1. __________________________

2. __________________________

3. __________________________

Recommendations:

Medications Prescribed: __________________________

Follow-up Arranged or Provided by Consultant:

☐ Further diagnostic testing

☐ Individual therapy

☐ Family therapy

☐ Medication management

☐ Group therapy

☐ Lab tests

☐ Return visit

Other Care Needed:

☐ Medication management by PCC

☐ Referrals recommended

☐ Follow-up recommended

☐ Other

Name (type or print) __________________________

FAX to ____________

# __________________________

Signature __________________________

contact person __________________________

Add disclaimer statement per your institution here: __________________________

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# Supplemental Appendix S11: Primary Care Referral and Feedback Form

*Pediatrics* 2010;125;S172

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