PRIMARY CARE REFERRAL AND FEEDBACK FORM

Date: ____________________ ( ) Initial ( ) Follow-up

Referring Physician Name:

Address: ____________________ City ____________________ State Zip

Fax: (______) ____________________ Phone: (______) ____________________

Patient 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

Other Care Needed:

- Medication management by PCC
- Referrals recommended
- Follow-up recommended
- Other

Name (type or print) ____________________ Signature ____________________

FAX to ____________________ # ____________________ contact person

Add disclaimer statement per your institution here: ____________________

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**Supplemental Appendix S11: Primary Care Referral and Feedback Form**

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