PM FORM 4.3.1
COMMUNICATION DOCUMENT

Print Form | Submit by Email

To: (Primary Care Provider Name): | Phone #

Address: | Fax #

From: Clinician Name: | Provider Agency Name:

Provider Agency Address: | Provider Agency Phone:

T/RBHA Name: | Provider Agency Fax:

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: | AHCCCS ID#:

Patient Date of Birth: | AHCCCS Health Plan Name:

Medicare ID#: | Medicare Advantage Plan Name:

I. REASON FOR THIS COMMUNICATION (Check all applicable reasons)

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

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:

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.

Effective Date: 12/15/2008 Last Revised 7/19/2007