

Behavioral Health Report Primary Care Physician

Community Fir	st Member Name:	
Date of Birth:		Member CFHP ID#
Primary Care P	Physician:	
Behavioral Hea	lth Provider (print	name, address, phone#):
Diagnosis:	Axis I:	
	Axis II:	
	Axis III:	
Brief Clinical St	tatus:	
Number of Sessions Provided		Anticipated Number of Additional Sessions:
For Psychiatrist	t only:	,
MEDICATION		STARTING DATE
Signature:		Date:

^{*}A release of information must be obtained before sending this information to the member's PCP.
*This form is required for all Community First Members.