



COMMUNITY FIRST HEALTH PLANS

Behavioral Health Report To Primary Care Physician

Community First Member Name: _____

Date of Birth: _____ Member CFHP ID# _____

Primary Care Physician: _____

Behavioral Health Provider (print name, address, phone#):

Diagnosis: Axis I: _____

 Axis II: _____

 Axis III: _____

Brief Clinical Status:

Number of Sessions Provided	Anticipated Number of Additional Sessions:

For Psychiatrist 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.