**BEHAVIORAL HEALTH DIAGNOSIS AND TREATMENT PLAN**

*(Please send after 1st or 2nd appointment)*

**TO: Primary Care Provider (PCP)** Address:

Phone: *Office:* *Cell:*

Email: Fax:

**FROM: Behavioral Health Provider**: Address:

Phone: *Office:* *Cell:*

Email: Fax:

**RE:** Patient Name: Date of Birth: \_

Preferred Phone #: Email:

**A release of information for this patient:** ☐ **is** **attached** ☐ **was sent previously**

The patient identified above: ☐Date last seen in our office: ☐Did not complete intake

*Intake Date(s):* \_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Initial Diagnoses:**

1. 2. 3. 4.

**Treatment Goals:**

**Primary Care Services Requested:**

☐ Psychotropic Medication Evaluation by PCP

☐ Rule out physical etiology of:

☐ Please email Referral to BH Services

☐ Other:­

**Treatment Plan:**

☐ Individual Therapy (Freq. of Visits: )

☐ Family Therapy (Freq. of Visits: )

☐ Group Therapy (Freq. of Visits: )

☐ Psychotropic Medication Evaluation (Prescribing psychiatrist: )

☐ Psychotropic Medication Management (Prescribing psychiatrist )

☐ Other (please describe):

**Referrals Made for Services Outside of this Mental/Behavioral Health Clinic/Practice:**

☐Psychoeducational Evaluation ☐Neuropsychological Evaluation ☐In-home Services ☐PHP/IOP☐Inpatient Hospitalization ☐Substance-use treatment ☐Other:

**Date of Next Appointment**:

**Please contact me with any questions or concerns at the following:**

☐Office Phone ☐Cell Phone ☐Email ☐Fax *(add contact info here if different from above)*

Best times to reach me:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Behavioral Health Provider Signature Date**