**BEHAVIORAL HEALTH TREATMENT UPDATE**

*(Please send when there is a significant change and/or quarterly)*

**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: \_

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

**Date patient was last seen: Date of next appointment: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

☐ **Patient has not been attending appointments**

**Patient’s diagnosis:**

**Changes in patient’s functioning since last update:**

***At home***: ☐Much Worse ☐Worse ☐No Change ☐A Little Better ☐A Lot Better

***At school***: ☐Much Worse ☐Worse ☐No Change ☐A Little Better ☐A Lot Better

***With peers:*** ☐Much Worse ☐Worse ☐No Change ☐A Little Better ☐A Lot Better

***Description of progress or deterioration in functioning*:**

**Treatment Plan Update(s):**

☐Continue previous treatment plan and goals

☐Change in treatment plan/goals

*(e.g., new concerns, additional services, change in frequency – describe below)*

**Psychotropic medications**: ☐ None ☐ Yes *(list below; attach additional pages as needed)*

*Medication Dose Prescriber name and phone number*

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**Behavioral Health Provider Signature Date**