**PEDIATRIC UPDATE**

*(Send when there is a significant change in functioning/symptoms)*

**TO: Behavioral Health Provider**: Address:

Phone: *Office:* *Cell:*

Email: Fax:

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

Phone: *Office:* *Cell:*

Email: Fax:

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

**A release of information for this patient:** ☐ **is** **attached** ☐ **has already been sent**

**Changes in medical condition, health status, or mental/behavioral health symptoms:**

☐ Significant Weight Changes: ☐ *gain* ☐ *loss* ☐ Frequent Headaches

☐ Frequent Nausea or Stomachaches ☐ Fatigue or Lack of Energy

☐ Sleep Disturbances: ☐ *difficulty falling asleep* ☐ *mid-sleep awakening* ☐*early a.m. awakening*

Other/Additional Concerns:

**Psychotropic medication changes for this patient?** ☐Yes ☐No ☐No medications

Specify changes:

*Medication Dose Start Date*

☐*Relevant labs or other reports attached*

**Additional comments, questions, or concerns about this patient’s medical condition, health status, or mental/behavioral health symptoms:**

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**Primary Care Provider Signature Date**