Will Davidson, LMHC Counseling

Combined Behavioral Health Provider / Primary Care Communication Form

Client Name ______________________ **DOB** ______________

Name of PCP ______________________ **Phone Number** ______________ **FAX** ______________

Mailing Address ____

☐ **Client Refuses to sign consent form** ☐ **Client has no PCP and needs a referral**

Behavioral Health Provider	Primary Care
1. The above-named client is being treated for the following behavioral health concerns (Including substance use disorders) and/or diagnoses:	**1. The above-named Patient is being treated for the following medical concerns (including substance use disorders) and/or diagnoses:**
2. The client is taking the following medication(s). (List all prescribed/OTC medications with dosage, frequency and prescriber as applicable):	**2. The Patient is taking the following medication(s). (List all prescribed/OTC medications with dosage, frequency and prescriber as applicable):**
3. Description of any special concerns:	**3. Description of any special concerns:**

4. Name of Behavioral Health Clinician:	**Will Davidson, LMHC**	**4. Name of Provider**	
5. Clinician Signature:		**5. Provider Signature:**	
6. Name of Center		**6. Name of Center**	
7. Center Address	**Will Davidson, LMHC Counseling 9 Cedar St Worcester, MA 01608**	**7. Center Address**	
8. Phone / Fax	**508-963-0805 - - 774-823-3591**	**8. Phone / Fax**	

I grant permission to (Physician's name) ______________________ **to disclose to and receive from Will Davidson, LMHC the following information: Admission notes, discharge summary, medical history, physical exam, psychological testing, educational testing, medication list, special concerns and relevant lab results. I understand that this information will be used to aid in my care and will increase communication and promote care coordination between providers.**

Signature of Patient or legal Guardian: ______________________ **Date:** ______________

Witness Signature: ______________________ **Date:** ______________