

I, \_\_\_\_\_, give my permission for Virginia Felder, L.M.F.T. to complete  
PRINT NAME

this form and send it to my Primary Care Physician, \_\_\_\_\_,  
PRINT NAME

located at \_\_\_\_\_.

I, \_\_\_\_\_, **DO NOT** give my permission.  
PRINT NAME

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**CONFIDENTIAL REPORT TO PRIMARY CARE PHYSICIAN FROM MENTAL HEALTH PROVIDER**

**Patient:** \_\_\_\_\_ **Member # :** \_\_\_\_\_

**DOB:** \_\_\_\_\_ **Date(s) Patient Seen:** \_\_\_\_\_

**Dear Dr.** \_\_\_\_\_,

This letter is sent so that your records can reflect the current mental health treatment this patient is receiving from me. To help in the collaborative management of this patient, *please complete the information* at the bottom of this sheet and mail or fax it back to me.

**Patient Diagnosis:** \_\_\_\_\_

**Special Precautions (potential risk of harm to self or others):** \_\_\_\_\_

**Psychotropic medications prescribed and by whom:** \_\_\_\_\_

**Stress related factors are: family; work; school; legal; death; divorce; financial; loss of significant other; social; spiritual; marital; other** \_\_\_\_\_

**Frequency of Treatment:** \_\_\_\_\_

**Severity of problem:** \_\_\_\_\_

**Treatment recommendations/ plans at this time include:** \_\_\_\_\_

Sincerely,

\_\_\_\_\_  
Signature and Credentials

\_\_\_\_\_  
Date

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Virginia Felder D.Min., L.M.F.T.  
4262 Smithsonia Court Tucker, GA 30084  
Phone: 770-908-0863 Fax: 770-908-0863

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PCP-Please complete and return via mail or fax to the Behavioral Healthcare Provider

**Date of last complete physical exam:** \_\_\_\_\_

**Any significant abnormal findings or lab values:** \_\_\_\_\_

**Current medications you have prescribed or are aware that the patient is taking:**

**Current concerns/ issues of which you should be aware:** \_\_\_\_\_

\_\_\_\_\_  
PCP Signature and Credentials

\_\_\_\_\_  
Date