

Practice Letterhead

Primary Care Physician/
Behavioral Health Clinician Name _____

Address _____

Fax # _____

Date _____

Dear Provider,

Your patient, _____, is being treated for symptoms of _____.
I/We have recommended the following treatment: _____ (diagnosis)

Individual Therapy

Group Therapy

Pharmacotherapy

Family/Couples Therapy

Psychiatric Evaluation for Medication

No treatment recommended at this time

The following medication(s) have been prescribed:

Medication _____	Dose/frequency _____
_____	_____
_____	_____

No medication at this time

Please feel free to contact me at 412-xxx-xxxx if you feel there are coordination of care issues that we should discuss.

Sincerely,

Dr Pepper
Licensed Psychologist