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REPORT TO PRIMARY CARE PHYSICIAN

Client Name: _____ **Date of Birth:** _____

Name of Physician: _____

Name of Practice/Address: _____

Physician Phone: _____ **Physician Fax:** _____

Please choose **ONE** of the following:

(1) _____ I **authorize** Dr. Deborah Carle to exchange information with my Primary Care Physician.
(2) _____ I **DO NOT** authorize Dr. Deborah Carle to exchange information with my Primary Care Physician.
(3) _____ I do not have a Primary Care Physician at this time.

Client/Guardian Signature: _____ **Date:** _____

FOR OFFICE USE ONLY

Suggested Diagnosis: _____

Reported Current Psychotropic Medications: _____
_____

Please evaluate client for the appropriate medication(s) for treatment of: _____
_____

Treatment Goals: _____
_____

Treatment Modalities:
_____ Individual Therapy _____ Family Therapy _____ Group Therapy _____ Couples Therapy
_____ Psychotropic Medication _____ Community Referral _____

Psychologist Signature:_____ Date: _____