

**A New Start Counseling Center, Inc.**  
115 Habersham Drive  
Fayetteville, Georgia 30214  
Tel: 770/ 461-9944 Fax: 770/ 461-9779

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**Primary Care Communication Form**

Patient's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Primary Care MD: \_\_\_\_\_

PCP Phone #: \_\_\_\_\_ PCP Fax #: \_\_\_\_\_

PCP Address: \_\_\_\_\_

\_\_\_\_\_ I give permission for my therapist to contact my Primary Care Physician and share protected health care information.

\_\_\_\_\_ I do not give permission for my therapist to contact my Primary Care Physician.

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Client Signature

Date

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**(This Section For Doctor Use Only)**

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

The above patient has received counseling services. I hope the following information will be helpful in coordinating care.

Date of initial evaluation \_\_\_\_\_.

DSM-IV Diagnosis: Axis I: \_\_\_\_\_ Axis II: \_\_\_\_\_ Axis III: \_\_\_\_\_

Other Considerations: \_\_\_\_\_

Treatment Plan:

Individual Counseling \_\_\_\_\_ X Month Family Counseling \_\_\_\_\_ X Month

Group Therapy \_\_\_\_\_ X Month Addiction Program \_\_\_\_\_ X Month

Other \_\_\_\_\_

Patient Education/ Instructions: \_\_\_\_\_

\_\_\_\_\_ I will follow this patient until the end of this episode.

\_\_\_\_\_ Please call me at your convenience to discuss this case.

\_\_\_\_\_ Please see attached additional information.

\_\_\_\_\_ Other

Therapist Name: \_\_\_\_\_

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