



# INTEGRATED BEHAVIORAL AND PHYSICAL HEALTH TRANSITION FORM

Patient's name \_\_\_\_\_ Psychiatrist \_\_\_\_\_  
 Date \_\_\_\_\_ NPI \_\_\_\_\_  
 Identification number \_\_\_\_\_ Region \_\_\_\_\_  
 Phone number \_\_\_\_\_ Phone number \_\_\_\_\_  
 Sex:  Female  Male Age \_\_\_\_\_

### Physical health diagnosis(es) if known

|                              | Yes                      | No                       | Unknown                  |
|------------------------------|--------------------------|--------------------------|--------------------------|
| _____ CVA / Stroke           | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| _____ Diabetes               | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| _____ Hypertension           | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| _____ COPD, Bronchial Asthma | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| _____ Cancer                 | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| _____ ESRD, HIV, Hepatitis C | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

### Laboratory results available

Dementic: Explain type \_\_\_\_\_  
 \_\_\_\_\_  
 Other \_\_\_\_\_

Patient has been under my treatment for \_\_\_\_\_  
(principal diagnosis)

### Mental health diagnosis

### ICD-9

Psychotherapy  Yes  No

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

### Actual treatment medications (Please include dosage and frequency)

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

### Specify frequency and provider

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

### Last mental health hospitalization (in the last 6 months)

Partial  IP   
 Facility \_\_\_\_\_  
 Admission from \_\_\_\_\_ to \_\_\_\_\_  
 Admission dx \_\_\_\_\_  
 Treatment plan \_\_\_\_\_  
 Post discharge visit: \_\_\_\_\_  
(Date)

Partial  IP   
 Facility \_\_\_\_\_  
 Admission from \_\_\_\_\_ to \_\_\_\_\_  
 Admission dx \_\_\_\_\_  
 Treatment plan \_\_\_\_\_  
 Post discharge visit: \_\_\_\_\_  
(Date)

### Final diagnosis:

|       |              |       |
|-------|--------------|-------|
| _____ | Axis I       | _____ |
| _____ | Axis II      | _____ |
| _____ | Axis III     | _____ |
| _____ | Axis IV      | _____ |
| _____ | Axis V       | _____ |
| _____ | GAF (Actual) | _____ |
| _____ | Best GAF     | _____ |

Date \_\_\_\_\_  
 Physician signature \_\_\_\_\_

NPI \_\_\_\_\_  
 License \_\_\_\_\_