NOVANT HEALTH | UVA HEALTH SYSTEM

Northern Virginia Psychiatric Associates

PRIMARY CARE NOTIFICATION LETTER

Date: _____

Primary Care MD: _____

Address: _____

_____

_____

Phone: _____

☐ I consent for this letter to be sent to the above Primary Care MD.

_____	_____	_____
Patient/Guardian Signature	Date Time	Printed Name

☐ I decline to have my Primary Care MD notified/involved in my treatment while at Northern Virginia Psychiatric Associates.

_____	_____	_____
Patient/Guardian Signature	Date Time	Printed Name

If limited English proficient or hearing impaired, offer interpreter at no additional cost:

☐ Interpreter Accepted _____ ☐ Interpreter Refused

(Name/Number of Person/Services Chosen/Used)

This letter provides notification that the above patient has entered into outpatient treatment at Northern Virginia Psychiatric Associates. The above consent allows for you, the Primary Care MD, to collaborate with the patient's provider regarding any changes in the treatment plan or medication regime. Please feel free to call the provider at 703-369-8060 to discuss the care and treatment of our mutual patient.

FOR OFFICE USE ONLY

Name of Patient: _____ DOB: _____

Date Patient Seen: _____

Provider: _____