Name: ____________________________________	**Date Completed** ___/___/____

Study Name: Suicide Prevention for Patients with Chronic Pain

We encourage all participants to talk with their primary health care providers about their participation in this study. We will also send a letter to your primary care provider to notify him/her about your participation in this study. We may contact your primary care provider if we have a concern about your health or safety. Please provide your primary care provider's name and contact information below.

Doctor's Name ____

Doctor's Phone Number____

Doctor's Address ____
____

____ Your Signature

_______________________ Date