



COORDINATION OF CARE

CHECKLIST

Patient Name:			_ DOB:		
Service and Start Date:					
Is there a Primary Care Physician (PCP)?					□ Declined
PCP Name:			_ Phone#	<u> </u>	
Fax or Email:					
Release of Information Signed?			□ Yes	□No	□ Declined
Is there another Behavioral Health Clinician?			☐ Yes	□ No	□ Declined
BH Clinician's Name/License:			_ Phone #:		
Fax or Email:					
Release of Information Signed?			□ Yes	□No	□ Declined
Is there another treatment provider?			□ Yes	□ No	□ Declined
Provider's Name/License:			_ Phone #:		
Fax or Email:					
Release of Information Signed?		□ Yes	□No	□ Declined	
Documentation of Contacts and Attempts to Coordinate Care:					
Date	Provider Contacted	Phone, Fax, Em	nail	Information Shared or Discussed	

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