



# COORDINATION OF CARE

## CHECKLIST

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Service and Start Date: \_\_\_\_\_ Provider: \_\_\_\_\_

**Is there a Primary Care Physician (PCP)?** ☐ Yes ☐ No ☐ Declined

PCP Name: \_\_\_\_\_ Phone#: \_\_\_\_\_

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, Email	Information Shared or Discussed

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