



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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