Coordination of Care Checklist

Patient Name: _____ DOB: _____

Service and Start Date: _____ Provider: _____

Is there a Primary Care Physician? ☐ Yes ☐ No ☐ Declined

PCP Name: _____ Phone #: _____

Fax or Email: _____

Release of Information Signed? ☐ Yes ☐ No ☐ Declined

Is there another Behavioral Health (BH) 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