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