Coordination of Care Checklist

Client Name: ______________________ DOB: ________________

Date of Admission to Services: ____________ Clinician: ________________

Is there a Primary Care Physician? ☐ Yes ☐ No

PCP Name: ____________________________ Phone #: ____________

Fax or Email: ____

Release of Information Signed? ☐ Yes ☐ No ☐ Declined

Is there another Behavioral Health (BH) Clinician? ☐ Yes ☐ No

BH Clinician'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**	**Contacted by Phone, Fax, Email**	**Information Shared or Discussed**