## **Coordination of Care Checklist**

Client Name:		DOB:			
Date of Admission to Services:		Clinicia	in:		
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
BH Clinician's N	Name/License:			Phone #:	
Fax or Email:					
Release of Info	rmation Signed?		☐ Yes	☐ No	Declined
Documentation of	of Contacts and Atten	npts to Coor	dinate Ca	re:	
Documentation of Date	of Contacts and Atten Provider Contacted	Contacted by Phone, Fax, Email			on Shared or Discussed
	Provider	Contacted by Phone,			on Shared or Discussed
	Provider	Contacted by Phone,			on Shared or Discussed
	Provider	Contacted by Phone,			on Shared or Discussed
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