Coordination of Care Checklist

Client Name: _____ **DOB: _____**

Date of Admission to Services: _____ **Clinician: _____**

Is there a Primary Care Physician? ____Yes ____No

PCP Name: _____

Phone Number/Fax Number: _____

Release of Information Signed? ___Yes ___No ___Refused

If Refused, Reason: _____

Is there another Behavioral Health (BH) Clinician? ____Yes ____No

Other BH Clinician's Name/License: _____

Phone Number/Fax Number: _____

Release of Information Signed? ___Yes ___No ___ Refused

If Refused, Reason: _____

Dates of Communication with PCP			Dates of Communication with Other BH Clinician		
PCP Communication Comments (include any problems with the communication process)			**Other BH Clinician Communication Comments (include any problems with the communication process)**		

Client Name: _____