Coordination of Care Form
Report to PCP/Psychiatrist
Behavioral Health Provider Name, credentials
Address
Phone # Fax #

NEW DIRECTIONS

I do/ do not authorize _____ to release information to my physician/psychiatrist._____
(Circle one) (Behavioral Health Provider Name) (Client Signature)

Client Name:	Physician Name:
Client DOB:	Physician phone#
Medicaid Id#	Physician fax#

For Behavioral Health Provider to Complete:

This is a(n) ____Initial Summary ____Interim summary _____Termination Summary

Diagnosis:

Axis I:_____

Axis II:_____

Psychotropic Medications:

Current medications:_____

Please evaluate this client for the appropriateness of medication for the treatment of: _____

_____

Current Treatment Goals:

_____

_____

_____

Current Treatment Modalities:

☐ Individual Therapy ☐ Family Therapy ☐ Group Therapy ☐ Couples Therapy ☐ Referral to Early Child Intervention

☐ Referral to community services _____

_____ _____

Behavioral Health Provider Signature Date

Please complete and return with medication name and dosage prescribed or if there are any medical conditions or medications that may be causing or contributing to this client's behavioral health symptoms.

Current Medications prescribed:_____

_____

Medical Conditions:_____

_____

_____ _____

PCP/Psychiatrist Signature Date