

## Behavioral Health/PCP Coordination of Care Form

*PCP Office: Please place copy of form in patient's chart.*

**This form is intended to coordinate care with primary care physicians and medical specialists. This is not intended to replace the agencies' existing release of information form.**

Section 1 – Client Information			
Primary care physician / provider / clinic	Phone number (   )	Fax number (   )	
Street address	City	State	Zip
Section 2 – Patient Information			
Patient name	Date of birth	Date of evaluation	
Section 3 – Clinical Information			
Reason for referral or care coordination			
Diagnoses			
Medications currently prescribed			
Treatment plan(s) or recommendations			
Other pertinent information			
Medical follow-up recommended			

Treating behavioral health provider \_\_\_\_\_

Phone number \_\_\_\_\_ Fax number \_\_\_\_\_ Date sent \_\_\_\_\_