

Your Practice Name and Logo Here

Coordination of Care Form

Patient _____ **DOB:** _____

To: _____

Date: _____

I am currently seeing this patient for:

	Individual Therapy
	Marital Therapy
	Family Therapy

I have requested the patient see you for:

	Evaluation for psychotropic meds
	Medication management
	Physical examination
	Blood panel evaluations
	Other _____

At this time, current working diagnosis:

	Depression	
	Anxiety Disorder	
	Bipolar Disorder	
	Panic Disorder	
	Adjustment Disorder	
	Other _____	

Expected course of treatment:

	Weekly
	2x a month
	Monthly
	As needed

Other concerns include:

	Suicidal thoughts/ideations
	Homicidal thoughts/ideations
	Domestic violence
	Substance abuse
	Other _____

Current medications patient indicates taking:

Comments:

****Please feel free to contact me with any concerns or information that might be needed for this patient's care.**

Signed _____
Therapist Name

Address
Phone
FAX

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