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CARE COORDINATION FORM*

Date: _____
To: _____
From: _____
RE: _____

I am currently seeing this client for:
- ☐ Individual therapy
- ☐ Marital therapy
- ☐ Family therapy

Expected course of treatment:
- ☐ Weekly
- ☐ 2 x per month
- ☐ Monthly
- ☐ As needed

At this time, my working diagnosis is:
- ☐ Major Depression
- ☐ Bipolar
- ☐ Anxiety Disorder
- ☐ Adjustment Disorder
- ☐ Other: _____

My other concerns include:
- ☐ Suicidal tendencies
- ☐ Homicidal ideations
- ☐ Domestic violence

I have requested the client see you for:
- ☐ Evaluation
- ☐ Medication management
- ☐ Physical examination
- ☐ Other
- ☐ None of the above

Current medication client indicates taking: _____

Comments: _____

_____ _____
Signature: Date:

* Signed Authorization to Disclose on File