COORDINATION OF CARE FORM

Patient: DOB:_____

Referred to: _____ Date:_____

- I give permission for my therapist or medical doctor to complete this form which I will bring to my appointment with _____
- Signed _____ Date _____

Referred by: _____, _____ Email: _____@_____Phone: _____

I currently see this patient for **Individual / Couples / Family / GroupTherapy**, _____ times per **Week / Month / As needed**.

I have requested the patient see you for:

	Evaluation for psychotropic meds
	Evaluation of current medication regime
	Medication examination
	Physical examination
	Possible Medical issues:
	Educational testing
	ADHD Screening
	Other:

At this time, current working diagnoses include:

	Depression	R/O
	Anxiety Disorder	R/O
	Bipolar Disorder	R/O
	ADHD	R/O
	Panic Disorder	R/O
	Adjustment Disorder	R/O
	PTSD	R/O
	Trauma	R/O
	Eating Disorder	R/O
	Substance Abuse/Alcoholism	R/O
	Other	R/O

Other concerns include:

	Suicidal Thoughts/ideations
	Homicidal Thoughts/ideations
	Anger/Domestic violence
	Self-Harm
	Problems at home
	Problems at work
	Sleep issues

Reported symptoms and additional information:

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