



CHP Coordination of Care Form

Section 1 – Patient Information	
Patient Name: _____	Birth Date: _____
Patient Contact Phone Number: _____	Referral/Consult Date: _____
Section 2 – Reason for Referral	
Patient having _____ symptoms.	
Needs _____	
<input type="checkbox"/> Evaluation for _____	Behavioral Health referral
<input type="checkbox"/> _____ Testing	<input type="checkbox"/> Psychiatrist
<input type="checkbox"/> _____ Surgery	<input type="checkbox"/> Psychologist
	<input type="checkbox"/> Counselor
Section 3 – Indicators	
<input type="checkbox"/> Chronic Illness	<input type="checkbox"/> Major Depressive Disorder
<input type="checkbox"/> Medical Comorbidities	<input type="checkbox"/> Addiction
<input type="checkbox"/> Medication Management	<input type="checkbox"/> Behavior Health Comorbidities
<input type="checkbox"/> Pain	<input type="checkbox"/> Other _____
Section 4 – Requested Services	
<input type="checkbox"/> One time consult (recommendations only)	<input type="checkbox"/> Referral (see and manage)
<input type="checkbox"/> Consult and Comanage	<input type="checkbox"/> Take over care
<input type="checkbox"/> Authorized for _____ visits	
Section 5 – Information Relevant to Consult	
<input type="checkbox"/> Recent labs	<input type="checkbox"/> History & Physical /Consults /Progress Notes
<input type="checkbox"/> Radiology	<input type="checkbox"/> Available electronically
<input type="checkbox"/> Current Medications	<input type="checkbox"/> Attached
Section 6 – Response Requested from Referring	
<input type="checkbox"/> Call A.S.A.P. after seeing the patient <input type="checkbox"/> Change medications as appropriate <input type="checkbox"/> Initiate treatment as appropriate <input type="checkbox"/> Consult with other sub-specialist as appropriate <input type="checkbox"/> Fax letter to my office before mailing <input type="checkbox"/> Please let me know if member did not keep appointment <input type="checkbox"/> Follow-up information available electronically <input type="checkbox"/> Follow-up information attached <input type="checkbox"/> Other _____ _____ _____	
Specialist Name: _____ Phone: _____ Fax: _____	
Date of Referral Appointment (initial appointment is made by PCP's office) _____	
Requesting Provider Signature: _____ Date: _____	
Specialist Signature: _____ Date: _____	

Please keep a copy of this form with the patient's record.