Lynne Coon, Licensed Professional Counselor (LPC)

Coordination of Care Form

Date:_____ **From:** _____

To _____

Patient _____ **DOB:** _____

Diagnosis:_____ **Treatment** _____

I am currently seeing this patient for:

	Individual Therapy
	Family Therapy

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

I have requested the patient see you for:

	Evaluation for psychotropic meds
	Medication management
	Physical examination
	Blood panel evaluations
	Other_____

Other concerns include:

	Suicidal thoughts/ideations
	Homicidal thoughts/ideations
	Domestic violence
	Substance abuse
	Other_____

Current medications patient indicates taking:

Comments:

Signed_____ Date_____
Lynne Coon, LPC.

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

• 1020 SW Taylor Street, Suite 448, Portland, OR 97205 • Phone: 503-243-2283 • Fax: 503-488-5997
E-mail: counselor@lynnecoon.com • www.counselorportlandoregon.com