Healing Hope Counseling Center, LLC

1601 E Dodge Street
Kokomo, IN 46902
765-280-7071

<u>Coordination of Care Form</u>

Client Name:______________________________DOB_________________________

Primary Care Physician:____

This letter is to inform you that the above named individual was seen in our office for an initial mental health assessment on __________________.

DX: __________________________________Seen for_____________________________

Recommendations based on assessment or visits:
____
____
____
____
____

I agree that a letter of coordination be sent to my physician.

Client Signature:_____________________________________

Therapist Signature:_________________________________
Date___________________

Signature of Parent or
Guardian:____