

MRN

BRIEF ID *(name, age, sex, gender)*

TREATING PCP *(to whom should the recommendation be sent?)*

LENGTH OF TIME IN COLLABORATIVE CARE

ENGAGEMENT WITH THE COLLABORATIVE CARE PROGRAM

REASON FOR INITIAL ENROLLMENT

CURRENT SYMPTOMS *(changes since last review – mood, affect, sleep, energy, memory, etc.)*

OUTCOME MEASURES – LAST TWO SCORES *(are scores increasing? decreasing?)*

	<i>most recent</i>		<i>previous to most recent</i>		
PHQ-9	SCORE:	DATE:	SCORE:	DATE:	↑ ↓
GAD-7	SCORE:	DATE:	SCORE:	DATE:	↑ ↓

SI/HI *(positive Q9? elaborate on nature of SI, along with safety planning and history)*

CURRENT PSYCHOTROPIC MEDICATIONS *(length, dose, efficacy, side effects, compliance)*

SUBSTANCE USE (*changes or new information since last review*)

MEDICAL CONDITIONS (*changes or new information since last review*)

PSYCHOSOCIAL CONCERNS (*changes or new information since last review*)

CURRENT TREATMENT PLAN (*next planned contact, psychoeducation provided, brief interventions, self-management plan, etc.*)

OTHER IMPORTANT DETAILS