Care Coordination Note Cheat Sheet

Reviewed by the BastionGPT Clinical Advisory Board · July 2026

A care coordination note documents the work of organizing a client's care across providers: contacts made, referrals and their status, consent to share information, handoffs, and outcomes. It is a record entry, not a billable service. Most run 75 to 250 words.

1 – Reason for coordination why this is happening, in one line
Do: name the trigger: a new referral, a care transition, a risk event, or a scheduled review.
Pitfall: a coordination note with no stated reason, which reads as time spent for no documented purpose.

2 – Participants & contacts who you reached, and how
Do: record name, role, organization, method (phone, secure message, portal, fax), direction, and date.
Pitfall: "coordinated with PCP" with no who, when, or how, which a reviewer cannot verify.

3 – Consent to share the authority for the disclosure
Do: name the basis: the treatment exception, a signed release on file, or a 42 CFR Part 2 consent for substance use records.
Pitfall: sharing protected information without naming what permits it.

4 – Referrals & status close the loop, do not just open it
Do: track each referral to whom and for what, and where it sits: sent, accepted, scheduled, completed, results returned.
Pitfall: documenting the referral sent and never closing the loop, so no one knows if the client arrived.

5 – Information exchanged & actions the substance and the tasks
Do: record what you shared or requested, the decisions reached, and each task with an owner.
Pitfall: "discussed case" with none of the substance or the decisions.

6 – Outcome & follow-up what happens next, and who owns it
Do: state the result, the next step, the responsible party, and the date or trigger for the next check.
Pitfall: a follow-up with no owner and no date, so the task falls through the transition.

Before you sign

- [ ] Reason for coordination stated in one line
- [ ] Each contact has a name, role, method, and date
- [ ] Consent basis named (treatment, release on file, or Part 2)
- [ ] Every referral shows a loop status, not just "sent"
- [ ] Follow-up has an owner and a date
- [ ] Time and who spent it recorded if a care-management service is billed

Drafting with AI

Capture a few bullets: who you contacted, why, what you shared, referral status, and the follow-up.

> *"Draft a care coordination note from these bullets: called PCP and inpatient social worker, transition after discharge, ROI on file, psychiatry referral scheduled, follow up in one week: …"*

Never paste client-identifying information into consumer AI tools. BastionGPT is HIPAA-compliant with a signed BAA on every plan.

75–250 words	**5–10 min by hand**	**When care crosses providers**	**Care team · payers · auditors**
typical length	clinical team estimate	when it's written	who reads it

Full guide, sample note, and compliance notes:
bastiongpt.com/template/care-coordination-note

Care Coordination Note Template

Copy or print for your practice · Adapt fields to your organization's, payer's and jurisdiction's documentation requirements.

Client (initials): Date: Clinician:

Reason for coordination
Trigger: new referral, care transition, risk event, or scheduled review

Participants & contacts
Name, role, organization, method (phone / secure message / portal / fax), direction, date

Consent to share
Basis: treatment exception / signed release on file (date) / 42 CFR Part 2 consent (date) / not applicable

Referrals & status
To whom and for what, urgency; sent / accepted / scheduled / completed / results returned

Information exchanged & actions
What you shared or requested, decisions reached, tasks assigned with an owner

Outcome & follow-up
Result, next step, responsible party, date or trigger for the next check

Time spent (if billing a care-management service): Performed by:

Clinician signature / credentials: Date signed: