

Coordinated Care Plan Update Template

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| Send this document via secure fax to the individual’s Lead Care Coordinator  |
| Lead Care Coordinator Name: Click here to enter text. | Agency: Click here to enter text. |
| Fax number: Click here to enter text. | Phone number: Click here to enter text. |
| Date: Click here to enter a date. |

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| Individual identifiers  |
| NE CCAC CHRIS Client number: Click here to enter text. |
| Given name: Click here to enter text. | Preferred name: Click here to enter text. | Surname: Click here to enter text. |
| Date of birth (dd/mm/yyyy): Click here to enter text. | Address: Click here to enter text. | City: Click here to enter text. |

**Coordinated Care Plan Updates**

Changes have been made to the following CCP domains (check all that apply). Please provide details of the update in the space provided.

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|  | CCP domain | Required update |
|[ ]  My identifiers | Click here to enter text. |
|[ ]  My care team | Click here to enter text. |
|[ ]  My health conditions | Click here to enter text. |
|[ ]  My situation and lifestyle | Click here to enter text. |
|[ ]  My assessed health needs | Click here to enter text. |
|[ ]  My most recent hospital visits | Click here to enter text. |
|[ ]  My current supports and services | Click here to enter text. |
|[ ]  My known, current medications | Click here to enter text. |
|[ ]  My other treatments | Click here to enter text. |
|[ ]  My daily routines | Click here to enter text. |
|[ ]  My appointments and referrals | Click here to enter text. |
|[ ]  My plan to achieve my goals for care | Click here to enter text. |
|[ ]  My plan for future situations | Click here to enter text. |

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| Other relevant information |
| Click here to enter text. |

**Documented consent**

This individual has provided consent to the collection, sharing, and storage of this update with the following:

[ ] Their care team members (as identified on their Coordinated Care Plan)

[ ] North East Community Care Access Centre

[ ] Health Sciences North

[ ] Canadian Mental Health Association-Sudbury/Manitoulin

[ ]  I confirm that I have received consent to share this update.

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| Submitted by (Name):Click here to enter text. |
| Agency:Click here to enter text. | Phone/email:Click here to enter text. |
| Signature: |