

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 | | |
| NELHIN – Home and Community Care 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 LHIN – Home and Community Care

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: | |

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| ***FOR USE BY LEAD CARE COORDINATOR ONLY***  Care team member notification sent to (\* a fax copy of updated CCP is sent to members without HPG access to CCP) | | | | |
| Care Team member Agency | | Team member name | Fax number | Copy of CCP attached \* |
|  |  |  |  | Yes  No |
|  |  |  |  | Yes  No |
|  |  |  |  | Yes  No |
|  |  |  |  | Yes  No |
|  |  |  |  | Yes  No |
|  |  |  |  | Yes  No |
|  |  |  |  | Yes  No |
|  |  |  |  | Yes  No |
|  |  |  |  | Yes  No |
|  |  |  |  | Yes  No |
|  |  |  |  | Yes  No |
|  |  |  |  | Yes  No |