

INSTRUCTIONS: Complete this form in collaboration with the Client and/or Health SDM, the Care Team, and HL Navigator.

A. Coordinated Care Plan (CCP) Details			
Date Developed:		Developed By:	
Next Review Date:		Reviewed By:	
B. Health Link (HL) Client Information			
Given name:	Preferred name:	Surname:	
Date of birth:	Telephone number:	Marital status:	
Health card number:	Official language:	Ethnicity / Culture:	
People who live with Client:		Where Client currently lives:	
People Client relies on most at home:		People who depend on Client:	
Main Client contact:	Relationship to Client:	Telephone number:	
Emergency contact:	Relationship to Client:	Telephone number:	
Name(s) of Power of Attorney (POA), or Substitute Decision Maker (SDM) for Health:		Telephone number of Power of Attorney (POA) or Substitute Decision (SDM) for Health:	
C. Health Link Client Care Team			
Name	Role or Relationship	Telephone #	Participated in CCP?Y/N
	Primary Health Contact / System Nav.		
	Health Link Care Navigator		
Has the Client and/or Health SDM been involved in the development of coordinated care plan?			

D. Client Medical Information

Medical Diagnosis:

Past Medical History *(May include allergies, significant surgeries and/or implanted devices such as pacemakers, transplants, stents.):*

Medications:

- See Attached (copies of medications from Pharmacies)
- Medication Review / Reconciliation Needed

Pharmacies Used in the Past 12 Months

Name	Tel

E. Client Goals For Health and Well-Being

Date Developed:

What is most important to the Client right now:

What does wellness mean to the Client:

What are the Clients strengths and weaknesses:

Expected Outcome
(What Client Hopes to Achieve)

Steps to Achieve Goal
(What Client Can Do to Achieve it)

Who Will be Responsible

Barriers and Challenges

Results So Far...

Review Date...

<p>Expected Outcome <i>(What Client Hopes to Achieve)</i></p>	<p>Steps to Achieve Goal <i>(What Client Can Do to Achieve it)</i></p> <hr/> <hr/> <hr/> <hr/> <hr/> <hr/> <hr/> <hr/> <hr/> <hr/>	<p>Who Will be Responsible</p> <hr/> <p>Barriers and Challenges</p>
<p>Results So Far...</p>		<p>Review Date...</p>
<p>Expected Outcome <i>(What Client Hopes to Achieve)</i></p>	<p>Steps to Achieve Goal <i>(What Client Can Do to Achieve it)</i></p> <hr/> <hr/> <hr/> <hr/> <hr/> <hr/> <hr/> <hr/> <hr/> <hr/>	<p>Who Will be Responsible</p> <hr/> <p>Barriers and Challenges</p>
<p>Results So Far...</p>		<p>Review Date...</p>

<p>Expected Outcome <i>(What Client Hopes to Achieve)</i></p>	<p>Steps to Achieve Goal <i>(What Client Can Do to Achieve it)</i></p> <hr/> <hr/> <hr/> <hr/> <hr/> <hr/> <hr/> <hr/>	<p>Who Will be Responsible</p> <hr/> <p>Barriers and Challenges</p>
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<p>Results So Far...</p>	<p>Review Date...</p>
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F. Client's Plan for Future Situations / Advanced Care Planning

<p>Do you have a plan for your future care? <input type="checkbox"/> YES <input type="checkbox"/> NO</p>	<p>Would you like more information to help make plans for your future care? <input type="checkbox"/> YES <input type="checkbox"/> NO</p>
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FOR HL NAVIGATORS ONLY: Copy of CCP provided to Primary Care Practitioner? YES NO

Comments: