

# PCP Service Coordination Plan

## Consumer Name

## Key Worker

Name \_\_\_\_\_

Agency \_\_\_\_\_

Contact number \_\_\_\_\_

Record Agency Assigned Consumer Identifier (key worker agency)

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or affix label here

## Review

Whole Plan to be reviewed                      Yes                      No

By \_\_\_\_\_ Date review recommended \_\_\_\_\_

## Participants in Care Planning Process

Consumer                      Yes                      No

Others:

Name	Relationship to consumer	Contact – phone	Other relevant contact details

Note: List key worker first. Include all participants in developing this plan - eg, GP, health & community care providers, substitute decision-maker, carer, family members, friends. Append sheet to specify any additional persons.

## Evidence of assessment of need

Document	Relevant?	Available?	Comments
INI Consumer / Summary and Referral Information	✓		
INI Supplementary Profiles			
Referral letter / form			
Service specific assessment/s			
Specialist assessment/s			
Comprehensive assessment/s			
Current care plan/s			
Previous care plan/s			
Other (specify):			

## Case Conference

No                                            Yes                                            If yes, date \_\_\_\_\_

Copy to Consumer?                      Yes                      No                      Copy to team members?                      Yes                      No

### Office Use Only

Service Coordination Plan documented by:

SCP Page 1 of 2

Name \_\_\_\_\_ Designation/Agency \_\_\_\_\_

Sign \_\_\_\_\_ Date \_\_\_\_\_ Contact number \_\_\_\_\_

*If information becomes superseded, indicate below and record updated information on a new form*

The information on this form has been superseded

Date: \_\_\_\_\_ Name: \_\_\_\_\_ Sign: \_\_\_\_\_

**PCP Service Coordination Plan**

**Consumer Name**

\_\_\_\_\_

Record Agency Assigned Consumer Identifier (key worker agency)

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or affix label here

Consumer Issue/Problem		
Goal	Target date	
Action/s to be taken		
Responsible individual/s or service/s		
Proposed start date	Review date	Issue resolved (date)

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Append more sheets as necessary

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Service Coordination Plan documented by:

SCP Page 2 of 2

Name \_\_\_\_\_ Designation/Agency \_\_\_\_\_

Sign \_\_\_\_\_ Date \_\_\_\_\_ Contact number \_\_\_\_\_

*If information becomes superseded, indicate below and record updated information on a new form*

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Date:

Name:

Sign: