Service Coordination Plan

Record Agency Assigned Consumer Identifier (key worker agency)

or affix label here

Consumer Name

Key Worker

Name | Agency | Contact number

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 number	Other relevant contact details

Note: List key worker first. Include all participants in developing this plan—e.g. GP, health and 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

Department of Human Services

1620402H

Office Use Only: Service Coordination Plan documented by:

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If information becomes superseded, indicate below and record updated information on a new form

The information on this form has been superseded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:

Service Coordination Plan

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or affix label here

Consumer Name

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):

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):

Append more sheets as necessary

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