Ontario
Local Health Integration Network
Réseau local d'intégration des services de santé

HealthLinks
South West Health Links
Let's Make Healthy Change Happen

Registration and Coordinated Care Plan (CCP) Entry

Coordinated Care Plan (CCP) Coordination Team:
Phone: 1-855-371-6337
Fax Form to: 1-833-815-5393

Name of Person Completing Form (print please):	
Contact Phone Number:	Date: (D/M/Y)

REQUEST FOR: O CCP entry O Update CCP O Close CCP O Open patient/client file (for HPG users only)

Patient Name:	Date of Birth: (D/M/Y)

CCP Word Document attached: ☐ Yes (go to section B or C) ☐ No (go to section A and B, or D)

Section A: (Complete for creating patient/client file)

Patient Information (patient addressograph/label can be used)	
Health Card Number:	Version Code:
Gender: ☐ F ☐ M ☐ Unspecified ☐ Unknown	Identifies as Indigenous: ☐ Yes ☐ No
Language of Comfort:	
Address:	
City:	Postal Code:
Phone Number:	Alternate Phone Number:
Primary Contact Name:	
Relationship:	Phone:

Section B: (Complete for data entry and patient/client file creation)

Requesting Organization Type: ☐ Hospital-Emergency Dept. ☐ Hospital-Out Patient ☐ Community ☐ Community Support Service Agency ☐ Primary Care Provider (including FHT and CHC) ☐ Mental Health and Addiction Agencies ☐ Other		
Lead Agency:		
Contact Name:	Phone #:	Fax #:
Date Patient Identified for CCP: (D/M/Y)		
Verbal Consent for CCP and Electronic Filing Obtained From:		Date: (D/M/Y)
CCP discussed with Patient ☐ Yes ☐ No	Date: (D/M/Y)	
Name of Patient's Primary Care Provider (PCP):		☐ No PCP
Health Link Region where Patient lives: ☐ Elgin ☐ Grey Bruce ☐ Huron Perth ☐ London Middlesex ☐ Oxford		

Section C: (Complete for updates to CCP)

Following sections were updated:

Section D: (Complete for Closing/Discharge of CCPs Only)

Closing/Discharge Reason: ☐ Patient/Family Preference ☐ Transfer to Another LHIN ☐ Other:	
Deceased: (check location) ☐ Home ☐ Hospital ☐ LTCH ☐ Palliative Care ☐ Residential Hospice ☐ Retirement Home ☐ Other	
End Date/Discharge Date: (D/M/Y)	
Care Plan Complete? ☐ Yes ☐ No	Care Plan Goals Met ☐ Yes ☐ No

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Coordinated Care Plan Consent Form

Multi-Agency Consent for the Collection, Use and Disclosure of Personal Health Information

Purpose of Consent Form: To provide consent for my Care Team to collaborate with me and with each other to develop my Coordinated Care Plan and support me in achieving my goals. This consent also allows for the collection, use and disclosure of personal health information.

My personal health information will be collected, used and disclosed for the development and facilitation of my Coordinated Care Plan and may be shared and used for the purpose of evaluating and improving care and related services. My Coordinated Care Plan may be collected, used and disclosed, both in a secure electronic system and/or on paper.

My Coordinated Care Plan and Personal Health Information will be documented within the South West Local Health Integration Network (LHIN) Client Health Record Information System (CHRIS), regardless of whether or not the South West LHIN is included in my Coordinated Care Plan, for the purpose of facilitating electronic sharing amongst my care providers.

By agreeing to the completion of a Coordinated Care Plan, I am consenting to the collection, use and disclosure of my personal health information among the following:

- My health care providers, and those I've indicated in my care plan, for the development and facilitation of my Coordinated Care Plan;
- South West LHIN contracted service providers that provide health care, equipment and supplies as involved in my care;
- Other Health Partners that assist in providing my health care;
- Authorized South West LHIN Staff;
- Health care partners through regional and provincial systems (e.g. Health Partner Gateway and ClinicalConnect); and
- Authorized health organizations for the purposes of evaluating and improving care and related services.

My personal health information will be held in confidence and maintained securely with the South West LHIN electronic medical record, in accordance with Ontario law under the Personal Health Information Protection Act (PHIPA). I have the right to know how my information is used, shared and how I can access my information.

This consent is valid until I no longer have a Coordinated Care Plan.

I may refuse to provide my consent or I can withdraw my consent at any time by contacting any member of my Care team. The Care Team includes individuals/organizations that I have consented to contribute to and be involved in my Coordinated Care Plan.

Verbal Consent as documented on Registration Form: ☐

Signed Consent:

Signature: _____ Relationship to Patient: _____

Date: _____