

Derbyshire Healthcare **NHS**



C

NHS Foundation Trust

Care Plan and Review

Ref:

Name and address:

Care Co ordinator: Tel:

Deputy Care Co-ordinator: Tel:

Consultant: Dr. Tel:

Emergency contact evenings/weekends: Tel:

Date of Birth _ _ / _ _ / _ _ _ _

Other No: Date(s) review held _ _ / _ _ / 20 _ _ Present: Apologies:

1. Recent progress, current situation

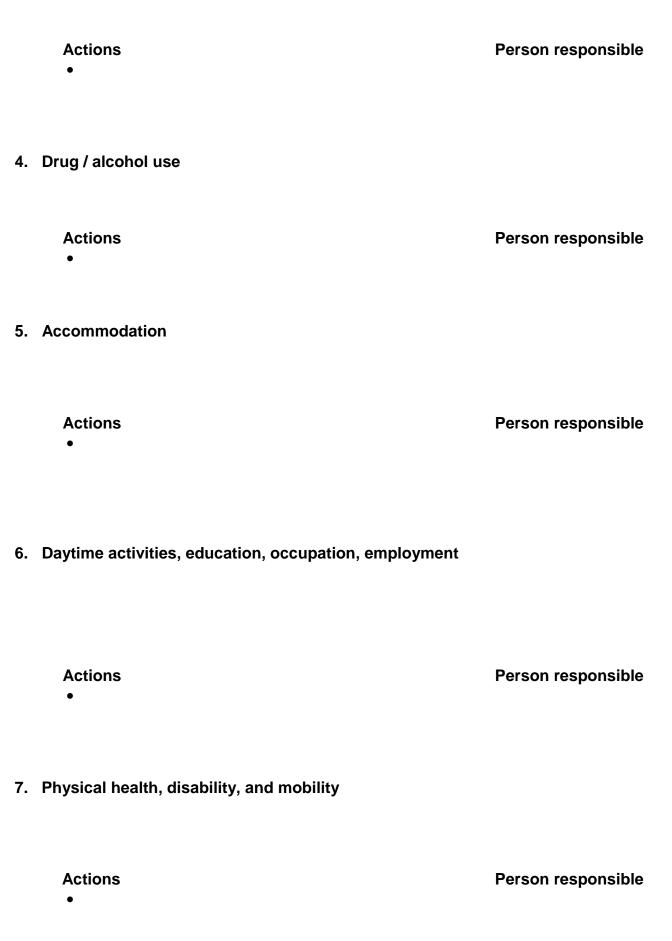
2. Mental health

Actions

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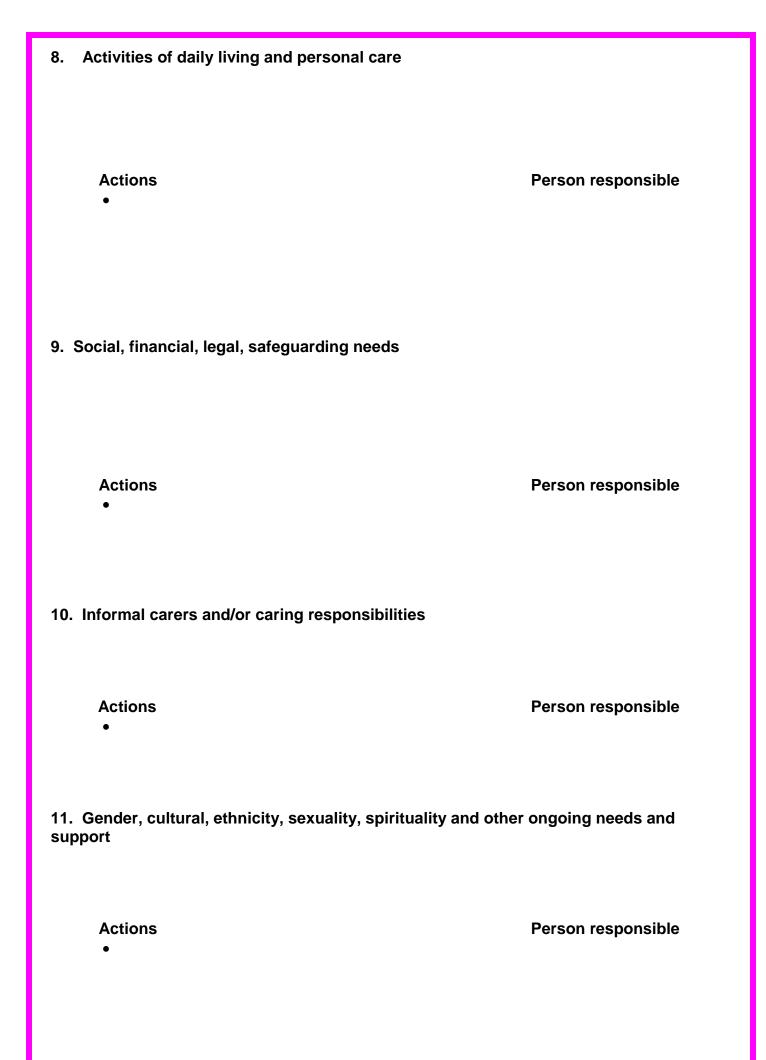
Person responsible

3. Medication (including information about who prescribes and where from, and any side effects)



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2



Agreed outcomes and Service Users views:

Relapse signature/risk management and Crisis and Contingency plan:

Care Co-ordinator's role:

Unmet Needs:

Needs the support of CPA?:		Yes / No
Advance Directive or Statement of wishes?		Yes / No
Entitlement under Section 117 of the Mental H	lealth Act 1983?	Yes / No
Direct Payments/Individual Budget included?		Yes / No
Change in employment/accommodation type:		Yes / No
Wellness/Recovery document?		. Yes / No
Outcome rating:		
I agree with the content of this Care Plan		
Signed (service user)	Date	e / / 20
□ Declined to sign □ Not available to sign □ Unable to sign because:		
Signed (care worker)	Date	e / / 20
Signed (Health / Social Services if Section 117 care plan) Date / / 20		
Next review date / / 20	Reviewed and still c	
Copies to:		ignature
Records Management Approved Clinical Document Issue 003 February 2011 4		