| **Shared Care PLAN (Sheet 1 of**   **)** |  | | |
| --- | --- | --- | --- |
| **Personal INFORMATION:**    GIVEN NAME/S FAMILY NAME (BLOCK LETTERS) of Consumer    Address:  Date of Birth: | | **Planning Coordinator/ Support coordinator:**  Service:      Phone: | |
| **Dates:**  Plan developed:  Team review frequency: | |
| |  |  |  |  |  | | --- | --- | --- | --- | --- | | **PARTIES TO THE PLAN** | Name/role | Contact details | Consent  Y/N | Preferred communication | | General practitioner: |  |  |  |  | | Private psychiatrist: |  |  |  |  | | Nominated carer/s: |  |  |  |  | | NDIS Support staff: |  |  |  |  | | AOD Practitioner: |  |  |  |  | | Clinical Mental Health Case Manager:  Psychiatrist: |  |  |  |  | | Other (Specify) |  |  |  |  | | Other (Specify) |  |  |  |  | | Other (Specify) |  |  |  |  | | Other (Specify) |  |  |  |  | | | | **Recovery Dimension**:  Each Recovery Dimension outlined should be relevant to the individual needs of the person who owns the plan.  The plan owner requires opportunity to name and preference their own needs and goals.  Refer to EMHSCA Shared Care Protocol. |

Shared Care Plan

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| **Recovery Dimension** | **Collaborative Goal** | **Date entered** | **Actions to be taken** | **PERSON(S) RESPONSIBLE** | **Progress** |

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| ………………………………Date: …/…/……  Plan owner’s signature  ……………………………………………Date: …./…./…  Nominated Carer’s signature | | | ……………………………………………Date:…./…/……  Planning Coordinator’s signature  Next scheduled Review Date: …./…./….. | | |

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| **Copy of Plan sent to the following:** | **Consent\***  **(Y/N)** |  | **Consent (Y/N)** |
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\*Indicate if consent to share the plan has been obtained and is current

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G:\Mental - Corrections - DA\MH\Operational\NEXUS\VDDI ETU 2012  Upgrade Working\AOD I Work Effectively in the AOD Sector\1A Welcome to AOD\Start Here\clip_image005.gif

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