



INTEGRATED CARE PLAN

Name: _____

Address: _____

Next of Kin: _____ D.O.B.: _____ Consultant: _____

<i>AIMS & OBJECTIVES</i>	<i>ACTIONS</i>	<i>THOSE RESPONSIBLE</i>
Mental Health	Mental Health	Mental Health



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<i>AIMS & OBJECTIVES</i>	<i>ACTIONS</i>	<i>THOSE RESPONSIBLE</i>
Physical Health	Physical Health	Physical Health



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<i>AIMS & OBJECTIVES</i>	<i>ACTIONS</i>	<i>THOSE RESPONSIBLE</i>
Daily Living Skills	Daily Living Skills	Daily Living Skills



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<i>AIMS & OBJECTIVES</i>	<i>ACTIONS</i>	<i>THOSE RESPONSIBLE</i>
Occupational Activities	Occupational Activities	Occupational Activities



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<i>AIMS & OBJECTIVES</i>	<i>ACTIONS</i>	<i>THOSE RESPONSIBLE</i>
Family Contact	Family Contact	Family Contact



INTEGRATED CARE PLAN

<i>AIMS & OBJECTIVES</i>	<i>ACTIONS</i>	<i>THOSE RESPONSIBLE</i>
Other Needs	Other Needs	Other Needs

Signed By:

Client:

Next of Kin:

Key Worker:

Date:

Date of Next Review:

Copies of Care Plan sent to:
