**Collaborative and Individualized Resource**

**Clinical Resource Plan ( updated by case manager)**

**Unique Identifier: Referral Date: (Y/M/D) Clinical Conference Review Date:**

**Personal Information**

Individuals Name: DOB (Y/M/D):

Mailing Address: Telephone:

Consent Provider/SDM Name: Telephone

(*If individual is unable to consent*) Email:

**Key Specialized Clinical Service Provider Contact Information:**

Agency: Contact Name: Telephone Number/Email:

**Case Management/Service Coordination Agency Contact Information :**

Agency: Contact Name: Telephone Number/Email:

**Other Key Agencies/ Persons:**

Agency: Contact Name: Telephone Number/Email:

**Clinical Resource Plan Reviewed by:**

**Name: Date:**

**Overarching Objective/Goals engaging with CAIR resources**

**Identify Client Strengths to build resilience**

**CLINICAL PLANS SHOULD:**

**(1)Identify Problems or Needs (2) Outline short/long term goals (3) Establish approaches and intervention to meet the goal**

**BIOLOGICAL ELEMENTS (*Medical, Physical, Genetic)***

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| --- |
| \*Have there been recent medical and dental exams? Any issues, treatment in progress? Is there a history of recurring medical/dietary/dental condition (digestive, ear, urinary, heart, respiratory, abscess)? Any noticeable change in eating, sleeping, physical routine/elimination, self care, energy level, mood, facial/communication/behavioral expressions? Any medication? Any side effects? What diagnosis? What else might be causing physical discomfort? Is there any syndromes/ predisposing genetic conditions? Any sensory limitations, sensitivity, vulnerabilities or disabilities (hearing, vision, sensitivity to touch, noise)? **What else?**  |

***\*Adapted from the “Over-to-U” tool developed by the Central Network of Specialized Care***

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Identify Presenting Issues or Needs** | **Short/Long Term Goals/Objectives**  | **Approaches/Intervention/Task**  | **Responsibility**  | **Date****Est.** | **Date****Achieved** |
|  |  |  |  | **00/00** | **00/00** |

**PSYCHOLOGICAL ELEMENTS (*Thoughts, Feelings, Behaviors, Internal resources* )**

|  |
| --- |
| \*Are there mood /behavior issues/ agitation, any pattern or trigger? Any changes in cognitive functioning (focus, concentration, orientation, communication)? Any unusual behaviours that are interfering with daily routine, normal enjoyment of the person and those around them? Are there aspects of this person’s developmental disability which are expressed through specific behaviours? Any changes in the person’s function/ adaptive skills? Any changes in positive and negative emotional expression? Have you reflected fully on this person’s internal resources (problem solving, ADL, personal skills, empathy), capabilities, on what they are able to do? **What else?**  |

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| --- | --- | --- | --- | --- | --- |
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|  |  |  |  | **00/00** | **00/00** |

**SOCIAL ELEMENTS (Environmental, Cultural, Spiritual, External Resources)**

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| --- |
| \*Any environmental sensitivities, requirements, accommodations regarding people, activities, transitions, routine/structure, physical stimuli (sound, touch, visuals), weather/season? Who does the person have in their formal and informal social support network? What activities have meaning for this person? Level of community participation (faith, club, group, recreational interest)? What do you know about this person’s story, family, cultural background, history of support and services? Any indentified family support needed? Is the community needs list and DSO list updated?Any environmental modifications needed? Any OT equipments  **What else?**  |

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| --- | --- | --- | --- | --- | --- |
| **Identify Presenting Issues or Needs** | **Short/Long Term Goals/Objectives**  | **Approaches/Intervention/Task**  | **Responsibility**  | **Date****Est.** | **Date****Achieved** |
|  |  |  |  | **00/00** | **00/00** |