Children's Treatment Centre
Quinte Health
Belleville General Hospital
265 Dundas Street East
Belleville, ON K8N 5A9

Telephone: **(613) 969-7400 x2247**
Fax: **(613) 968-9154**
www.quintectc.com

Coordinated Service Planning (CSP) Update Form

CONFIDENTIAL

Fax to 613-961-2529   Questions? Call 613-969-7400 x2508

☐ Q1: Apr to Jun   ☐ Q2: Jul to Sep   ☐ Q3: Oct to Dec   ☐ Q4: Jan to Mar

*All Community Planning Coordinators who Lead a CSP must submit this form at least quarterly
Due by the 10th day of the month following each quarter end

REFERRAL SOURCE INFORMATION

Name of Referring Individual:		
Agency/Organization:		
Address (*Ref Ind or Org*):	City:	Postal Code:
Phone Number:	Date: *(dd / mmm / yyyy)*	

CLIENT INFORMATION

Last Name:	First Name:	
Date of Birth: *(dd / mmm / yyyy)*	Gender: ☐ Female ☐ Male ☐ Other	Phone Number:
Address:	City:	Postal Code:

PARENT/GUARDIAN INFORMATION

PRIMARY CONTACT   Last Name: First Name:

Relationship to Child: *(if other or Agency, please specify)*

(check all that apply) ☐ Legal Guardian   ☐ Lives with Child

Home Phone:	Mobile:	Email:

☐ Address is same as the child's   ☐ Address is other than child's *(if Other, provide address below)*

Address:	City:	Postal Code:

SECOND CONTACT   Last Name: First Name:

Relationship to Child: *(if other or Agency, please specify)*

(check all that apply) ☐ Legal Guardian   ☐ Lives with Child

Home Phone:	Mobile:	Email:

☐ Address is same as the child's   ☐ Address is other than child's *(if Other, provide address below)*

Address:	City:	Postal Code:

DECISION-MAKING RESPONSIBILITY

Decision-Making Responsibility: ☐ No formal agreement   ☐ Formal agreement in place   ☐ Parents live together with child

If formal agreement in place, please describe (eg. sole, joint, etc.):

If parents are not together, all legal guardians are aware of and have consented to this referral: ☐ N/A   ☐ Yes   ☐ No

*(if No, referral **CANNOT** be processed)*

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INFORMATION UPDATE

i.	**First meeting with the family**	☐	Meeting Date:
ii.	**Initial CSP completed**	☐	Meeting Date:
	*Please fax copy of CSP document with this form		Frequency CSP will be monitored:
iii.	**Change or update to existing CSP**	☐	Meeting Date:
	*Please fax copy of CSP document with this form		Frequency CSP will be monitored:
iv.	**Change file to inactive status**	☐	
v.	**Change file from inactive status to active status**	☐	
vi.	**Change file to discharge status**	☐	Discharge Date:
vii.	**Change to contact information**	☐	Who:

Address:

City: _____ Postal Code: _____

Phone:

viii.	**Change to service providers**	☐

Service Name	Contact Name	Phone Number/Extension		
			☐ Add	☐ Remove
			☐ Add	☐ Remove
			☐ Add	☐ Remove

ix.	**Change to HPEN consent form**	☐	**Please fax copy of Consent forms with this form*

CSP DATA TRACKING *for this quarter only*

Direct Contact: person-to-person contact (in person or on the phone) with the child/youth/family
Each square represents ¼ hr (15 minutes) of time. Track number of visits and time spent by placing visit number in as many boxes as needed to reflect session length.

Sample direct	1	2	3	3	3	3	4	4	5	6	7	7	8	8	8	9
Totals:	# of Visits: 9								Direct hours: 4							

Totals:	# of Visits: _____								Direct hours: _____							

Indirect Contact: case planning, coordination, etc., done without the child/youth/family
Each square represents ¼ hr (15 minutes) of time. Track visit time by placing an X in as many boxes as needed

Sample indirect	X	X	X	X	X	X	X	X	-	-	-	-	-	-	-	-
Total:	Indirect hours: 2.25															

Total:	Indirect hours: _____															