MEDICATION SERVICES CLIENT PLAN

Name:	
InSyst #:	
RU#:	

MED. PLAN TYPES ***(check one):***	□ **Initial**	□ **Update** ***(includes Annual)***

LIFE GOALS: *CLIENT'S DESIRED RESULTS FROM MH INTERVENTIONS (Client quote if possible)*

CLIENT/FAMILY STRENGTHS *TOWARD OVERCOMING BARRIERS AND ACHIEVING DESIRED MH RELATED RESULTS*

DISCHARGE PLAN *(readiness/timeframe/expected referrals/etc.):*	

SHORT–TERM MENTAL HEALTH OBJECTIVES (SMART):

MH OBJECTIVE # 1	**Target Date:** 12 MONTHS or: _____
MH OBJECTIVE # 2	**Target Date:** 12 MONTHS or: _____

SERVICE MODALITY AND IT'S DETAILED INTERVENTIONS:

MODALITY	**Detailed Intervention(s):**	**Optional:** *Check any Individuals involved--not limited to.*
MEDICATION SERVICES MONTHLY, OR AS NEEDED, FOR 12 MONTHS		□ Case Manager □ Clinician □ MD/NP/PA □ Peer □ Family Partner □ Other:_____

Client or Parent/Caretaker: By signing, I agree that I have: 1) participated in the development of the Treatment Plan, and 2) have been offered a copy.	DATE
CLIENT/GUARDIAN/PARENT (IF NO SIGNATURE, PLEASE SEE PROGRESS NOTE DATED:_____ FOR EXPLANATION & WHEN NEXT ATTEMPT WILL BE).	

PSYCHIATRIST/NURSE PRACTITIONER/ETC. SIGNATURE (MUST BE LEGIBLE)	INDICATE LICENSED M/C CREDENTIAL: MD, NP, etc.	