Person's Name (First MI Last):			**Record #:**
D.O.B:	**Age:**	**Plan Completed by (Name, Title, Program):**	
Organization Name:			
Start Date:	**Target Completion Date:**	**Adjusted Target Date:** **Reason for adjustment:**	

Desired Outcomes in Person's Served Words:

State Goal below in Collaboration with the Person Served as identified in the: ☐ Psychiatric Evaluation and/or ☐ Comp. Assessment

☐ 1. Person Served will remain psychiatrically stable by reducing his/her signs and symptoms of mental illness and maximizing his/her level of independence.
☐ 2. Person Served will be able to recognize, accept, and manage his/her mental illness, including working with the medical staff to manage his/her medications.
☐ 3. Person Served will establish chemical dependence recovery that leads to improved physical and mental health.
☐ 4. Other:

Objectives:

☐ 1. Person's served current signs and symptoms will be reduced through the use of appropriate psychiatric medications.

☐ 2. Person served and medical staff will develop a medication regimen that is effective in reducing signs and symptoms while limiting side effects, including impact of co-morbid medical conditions.

☐ 3. Person's served mental status will improve or remain stable.

☐ 4. Person served will assist medical staff in monitoring side effects through appropriate lab work, monitoring of vital signs, and direct observation/reporting.

☐ 5. Person served will be able to list medications, uses, and benefits.

☐ 6. Person served will take medications as prescribed.

☐ 7. Person served will take medications as prescribed with the assistance of medical staff for administration of medications or monitoring self-administration.

☐ 8. Person served will understand and manage other lifestyle activities that may increase symptoms or medication side effects, e.g., substance use, caffeine, weight control, other diet, etc.

☐ 9. Other:

Person's Strengths and Skills and How They Will be Used to Meet Goals:

Therapeutic Intervention Methods	**Provider**	**Frequency**	**Duration**
☐ Medication Management	☐ MD/DO ☐RNCS ☐NP	☐ Weekly ☐ Other (list): ☐ Monthly ☐ Quarterly	☐1 Month ☐ 9 Months ☐ 3 Months ☐1 Year ☐ 6 Months ☐Other:
☐ Medication Education / Symptom / Illness Management	☐ MD/DO ☐RNCS ☐ RN ☐ NP ☐ Other (list):	☐ Weekly ☐ Other (list): ☐ Monthly ☐ Quarterly	☐1 Month ☐ 9 Months ☐ 3 Months ☐1 Year ☐ 6 Months ☐Other:
☐ Injections	☐ MD/DO ☐RNCS ☐ RN ☐ NP ☐ Other (list):	☐ Weekly ☐ Other (list): ☐ Monthly ☐ Quarterly	☐1 Month ☐ 9 Months ☐ 3 Months ☐1 Year ☐ 6 Months ☐Other:
☐ Physical Assessment (Vital signs, AIMS, weight, etc).	☐ MD/DO ☐RNCS ☐ RN ☐ NP ☐ Other (list):	☐ Weekly ☐ Other (list): ☐ Monthly ☐ Quarterly	☐1 Month ☐ 9 Months ☐ 3 Months ☐1 Year ☐ 6 Months ☐Other:
☐ Coordination	☐ MD/DO ☐RNCS ☐ RN ☐ NP ☐ Other (list):	☐ Weekly ☐ Other (list): ☐ Monthly ☐ Quarterly	☐1 Month ☐ 9 Months ☐ 3 Months ☐1 Year ☐ 6 Months ☐Other:
☐ Other	☐ MD/DO ☐RNCS ☐ RN ☐ NP ☐ Other (list):		☐1 Month ☐ 9 Months ☐ 3 Months ☐1 Year ☐ 6 Months ☐Other:

Referrals/Additional Evaluations ☐ None required
☐ Physical Assessment ☐ Substance Abuse Assessment ☐Neurological Consult ☐ Psych Testing ☐ Neuropsych Testing
☐Nutritional/Dietician ☐Other (list):

Explained rationale, benefits, risks, and treatment alternatives to/for the Person Served? ☐Yes ☐No

Transition/Level of Care Change/Discharge Plan	**Anticipated Date:**
Criteria - *How will the provider/person served/parent/guardian know that level of care change is warranted?* (check all that apply): ☐ Psychopharmacology Services are no longer medically necessary. ☐ Other:	

Person Served / Guardian Response	☐ Person Served: ☐Understands Information ☐Does not Understand ☐Agrees with Medication ☐Refuses Medication ☐ Guardian: ☐Understands Information ☐Does not Understand ☐Agrees with Medication ☐Refuses Medication Comments:
If the Person Served refuses plan, describe plan for continuation of services:	
The Person Served received a copy of the IAP? ☐Yes ☐No (explain):	

Person's Served Signature:	**Date:**
Parent/Guardian Signature: ☐ Not applicable	**Date:**
RN/RNCS/NP/APRN Signature/Credentials: ☐ Not applicable	**Date:**
Psychiatrist/MD/DO Signature/Credentials: ☐ Not applicable	**Date:**