Treatment Plan – Behavioral Health

Patient Name: Date of Session Created:
Patient DOB: Referring Provider:
Diagnosis:

Problems: _____

_____

Long Term Goals: _____

_____

Patient Strengths and Assets: _____

_____

Discharge Criteria: _____

_____

Problem(s):	Short Term Goal(s) and Objectives:	Target Date:	Date Complete:	Tx. Interventions (Methods, Frequency, Responsible Staff):
				Frequency/Duration BH clinician

This treatment plan and attendant risks and benefits have been explained to me. I understand and consent to this treatment plan. I have been offered a copy of this plan and accepted ☐ declined. ☐

_____/___/__ _ _____/___/__
Signature of Patient (optional if under 14 years old) Date Signature of Guardian (if needed) Date

_____ _____/__/_____
Signature of Clinician/Credentials Date Time Signature of Provider Date
I have reviewed the case and Treatment/Service Plan. I approve its implementation.

_____/__/__
Signature of Patient (optional if under 14 years old) Date

_____ _____/__/_____
Signature of Clinician/Credentials Revision Date Time Signature of Provider Revision Date
I have reviewed the case and Treatment/Service Plan. I approve its implementation.