



Individualized Action Plan Revision/Review-Psychopharmacology

Revision Date: 11-1-12

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| Organization Name: | | Program Name: | |
| Individual's Name (First / MI / Last): | | Record #: | DOB: |
| Review/Revision Date: | <input type="checkbox"/> Review <input type="checkbox"/> Revision | Next Review Due By: | |
| Goal & Objective Status (Continued/New/Discontinued/Attained/Revised) | | Evidence of Progress, Barriers, and/or Rationale for Attainment, Addition of New Goal/Discontinuation of Goal, Revision or Continuation: | |
| <input type="checkbox"/> Goal #1: Maximize Individual's independence by reducing/managing disabling psychiatric symptoms. | | <input type="checkbox"/> Continued <input type="checkbox"/> New - Linked to Prioritized Assessed Need # _____ From Form Dated: _____ <input type="checkbox"/> Discontinued – actual date of goal discontinuation: _____ <input type="checkbox"/> Attained– actual date of goal attained: _____ <input type="checkbox"/> Revised - Goal sheet attached | |
| <input type="checkbox"/> Obj. A <input type="checkbox"/> C <input type="checkbox"/> N <input type="checkbox"/> D <input type="checkbox"/> A <input type="checkbox"/> R <input type="checkbox"/> Obj. B <input type="checkbox"/> C <input type="checkbox"/> N <input type="checkbox"/> D <input type="checkbox"/> A <input type="checkbox"/> R <input type="checkbox"/> Obj. C <input type="checkbox"/> C <input type="checkbox"/> N <input type="checkbox"/> D <input type="checkbox"/> A <input type="checkbox"/> R <input type="checkbox"/> Obj. D <input type="checkbox"/> C <input type="checkbox"/> N <input type="checkbox"/> D <input type="checkbox"/> A <input type="checkbox"/> R <input type="checkbox"/> Obj. E <input type="checkbox"/> C <input type="checkbox"/> N <input type="checkbox"/> D <input type="checkbox"/> A <input type="checkbox"/> R <input type="checkbox"/> Obj. F <input type="checkbox"/> C <input type="checkbox"/> N <input type="checkbox"/> D <input type="checkbox"/> A <input type="checkbox"/> R | | Summary of Progress: | |
| <input type="checkbox"/> Goal # 2: Maintain chemical dependence recovery for improved mental and physical health. | | <input type="checkbox"/> Continued <input type="checkbox"/> New - Linked to Prioritized Assessed Need # _____ From Form Dated: _____ <input type="checkbox"/> Discontinued – actual date of goal discontinuation: _____ <input type="checkbox"/> Attained– actual date of goal attained: _____ <input type="checkbox"/> Revised - Goal sheet attached | |
| <input type="checkbox"/> Obj. A <input type="checkbox"/> C <input type="checkbox"/> N <input type="checkbox"/> D <input type="checkbox"/> A <input type="checkbox"/> R <input type="checkbox"/> Obj. B <input type="checkbox"/> C <input type="checkbox"/> N <input type="checkbox"/> D <input type="checkbox"/> A <input type="checkbox"/> R <input type="checkbox"/> Obj. C <input type="checkbox"/> C <input type="checkbox"/> N <input type="checkbox"/> D <input type="checkbox"/> A <input type="checkbox"/> R <input type="checkbox"/> Obj. D <input type="checkbox"/> C <input type="checkbox"/> N <input type="checkbox"/> D <input type="checkbox"/> A <input type="checkbox"/> R <input type="checkbox"/> Obj. E <input type="checkbox"/> C <input type="checkbox"/> N <input type="checkbox"/> D <input type="checkbox"/> A <input type="checkbox"/> R <input type="checkbox"/> Obj. F <input type="checkbox"/> C <input type="checkbox"/> N <input type="checkbox"/> D <input type="checkbox"/> A <input type="checkbox"/> R | | Summary of Progress: | |
| <input type="checkbox"/> Goal # 3: Reduce (or Discontinue) Medication Regime. | | <input type="checkbox"/> Continued <input type="checkbox"/> New - Linked to Prioritized Assessed Need # _____ From Form Dated: _____ <input type="checkbox"/> Discontinued – actual date of goal discontinuation: _____ <input type="checkbox"/> Attained– actual date of goal attained: _____ <input type="checkbox"/> Revised - Goal sheet attached | |
| <input type="checkbox"/> Obj. A <input type="checkbox"/> C <input type="checkbox"/> N <input type="checkbox"/> D <input type="checkbox"/> A <input type="checkbox"/> R <input type="checkbox"/> Obj. B <input type="checkbox"/> C <input type="checkbox"/> N <input type="checkbox"/> D <input type="checkbox"/> A <input type="checkbox"/> R <input type="checkbox"/> Obj. C <input type="checkbox"/> C <input type="checkbox"/> N <input type="checkbox"/> D <input type="checkbox"/> A <input type="checkbox"/> R <input type="checkbox"/> Obj. D <input type="checkbox"/> C <input type="checkbox"/> N <input type="checkbox"/> D <input type="checkbox"/> A <input type="checkbox"/> R <input type="checkbox"/> Obj. E <input type="checkbox"/> C <input type="checkbox"/> N <input type="checkbox"/> D <input type="checkbox"/> A <input type="checkbox"/> R <input type="checkbox"/> Obj. F <input type="checkbox"/> C <input type="checkbox"/> N <input type="checkbox"/> D <input type="checkbox"/> A <input type="checkbox"/> R | | Summary of Progress: | |
| <input type="checkbox"/> Goal # 4: | | <input type="checkbox"/> Continued <input type="checkbox"/> New - Linked to Prioritized Assessed Need # _____ From Form Dated: _____ <input type="checkbox"/> Discontinued – actual date of goal discontinuation: _____ <input type="checkbox"/> Attained– actual date of goal attained: _____ <input type="checkbox"/> Revised - Goal sheet attached | |
| <input type="checkbox"/> Obj. A <input type="checkbox"/> C <input type="checkbox"/> N <input type="checkbox"/> D <input type="checkbox"/> A <input type="checkbox"/> R <input type="checkbox"/> Obj. B <input type="checkbox"/> C <input type="checkbox"/> N <input type="checkbox"/> D <input type="checkbox"/> A <input type="checkbox"/> R <input type="checkbox"/> Obj. C <input type="checkbox"/> C <input type="checkbox"/> N <input type="checkbox"/> D <input type="checkbox"/> A <input type="checkbox"/> R <input type="checkbox"/> Obj. D <input type="checkbox"/> C <input type="checkbox"/> N <input type="checkbox"/> D <input type="checkbox"/> A <input type="checkbox"/> R <input type="checkbox"/> Obj. E <input type="checkbox"/> C <input type="checkbox"/> N <input type="checkbox"/> D <input type="checkbox"/> A <input type="checkbox"/> R <input type="checkbox"/> Obj. F <input type="checkbox"/> C <input type="checkbox"/> N <input type="checkbox"/> D <input type="checkbox"/> A <input type="checkbox"/> R | | Summary of Progress: | |



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| Name (First / MI / Last): | D.O.B.: |
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| Transition / Discharge Criteria <input type="checkbox"/> No Change) | For COA Only: Estimated Length of Treatment and Stay: |
| Criteria - How will the provider/individual/guardian know that care has been completed or that a transition to a lower level of care change is warranted? <i>(For OMH Housing Programs for Children and Adolescents, Include a description of the skills needed to return home or into the community / Check All that Apply):</i> <input type="checkbox"/> Reduction in symptoms as evidenced by: <input type="checkbox"/> Attainment of higher level of functioning as evidenced by: <input type="checkbox"/> Treatment is no longer medically necessary as evidenced by: <input type="checkbox"/> Other: | |

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| Individual has participated in the development of this plan <input type="checkbox"/> Yes <input type="checkbox"/> No, Provide reason: |
| Other (s) participated in the development of this plan <input type="checkbox"/> Yes <input type="checkbox"/> No, If Yes List names: |

| | | |
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| Individual Served | Individual Served Signature | Date: |
| Parent/Guardian/Other Name <input type="checkbox"/> (N/A): | Parent/Guardian/Other Signature: | Date: |

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| If lacking signature of Individual/Parent/Guardian, provide reason for non-participation: |
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| NPP - Print Name/Credentials <input type="checkbox"/> (N/A): | NPP Signature: | Date: |
| Psychiatrist/MD/DO - Print Name/Credentials: <input type="checkbox"/> (N/A): | Psychiatrist/MD/DO Signature: | Date: |

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| If Applicable, Additional Staff Sign Below | | |
| Print Staff Name/Credentials <input type="checkbox"/> (N/A): | Staff Signature: | Date: |
| Print Staff Name/Credentials <input type="checkbox"/> (N/A): | Staff Signature: | Date: |
| Print Staff Name/Credentials <input type="checkbox"/> (N/A): | Staff Signature: | Date: |
| Print Staff Name/Credentials <input type="checkbox"/> (N/A): | Staff Signature: | Date: |