Information of Treatment Plan Drafter

Date

**Assisted Community Treatment – Treatment Plan**

**Subject Name - DOB**

1. **Treatment Plan Summary:**
2. *Medications/Classes of Medications*
3. *Supportive Mental Health Treatment*
4. *Non-Mental Health Treatment*
5. **Clinical Status:**

*Relevant background information on the Subject.*

*Subject’s current diagnoses include (please list all relevant psychiatric, and medical diagnoses):*

*Clinical course - include signs, symptoms, and behavior*

*Treatment compliance – refusing medications or not agreeing to change in medication*

*regimen, include dates, indicate if patient is giving reason(s) why he/she is refusing*

*medications*

*History of Dangerous behaviors that support ACT – threatening, assaultive or self-harm behaviors, prior determination(s) of dangerousness*

1. **Proposed Medication Plan and Medication Information:**

*If applicable*

*List the classes of medication recommended for the treatment plan. The different types of medication listed in a class can be included if there a potential to use alternate types in the course of the Subject’s treatment.*

1. **Medical Appropriateness of Recommended Medications:**

**5. Supportive Mental Health Treatment**

*If applicable*

**6. Non-Mental Health Treatment**

*If applicable*

**7. Inadequacy of Less Intrusive Alternatives:**

**8. Physician/APRN/Designated Mental Health Program Responsible for the Coordination of Care**

*Name, Organization, Address, phone, email, fax etc. May also include a description of the treatment/services the provider will render.*

**9. Conclusion**

*Name, Signature, Date*