



MEDICATION SUPPORT CLIENT PLAN

Diagnostic Symptoms and Related Impairments

Diagnostic (DX) Symptoms:

Observable, measurable, functional impairments related to DX Symptoms:

(Individually based) (how symptoms present themselves in behavioral events or episodes)

Clients' Desired Outcomes

Client Driven Goals *(negotiated with individual) (structured format)*

To be achieved by _____
(goal target date)

1. Client will _____ from _____ times per _____
(select one) (observable, measureable behavior) (Frequency) (hr., day, wk., mo.)

To a goal of _____ times per _____ / _____ as measured by _____
(<or>)(frequency) (hr.,day,wk.,mo.) (sustained for) (self-report, observation, collateral report, etc.)

2. Client will _____ from _____ times per _____
(select one) (observable, measureable behavior) (Frequency) (hr., day, wk., mo.)

To a goal of _____ times per _____ / _____ as measured by _____
(<or>)(frequency) (hr.,day,wk.,mo.) (sustained for) (self-report, observation, collateral report, etc.)

3. Client will _____ from _____ times per _____
(select one) (observable, measureable behavior) (Frequency) (hr., day, wk., mo.)

To a goal of _____ times per _____ / _____ as measured by _____
(<or>)(frequency) (hr.,day,wk.,mo.) (sustained for) (self-report, observation, collateral report, etc.)

(Also see MSS ID notes and order sheets as part of the Plan for MSS)

Strengths:

- Family Support Participate actively in treatment Clean and sober
- Awareness of psychiatric condition Compliant with treatment and follow up appointments
- Other (Describe): _____



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Interventions:

- Provide medication evaluation/prescriptions/monitoring as indicated: _____
(appointment frequency)
- Provide supervision for case management services Coordinate with support system
- Educate patient on medication and side effects Psychosocial education
- Educate patient to appropriately utilize community resources
- Encourage participation in other treatment services:
- Mental Health Counseling Alcohol and Drug Counseling Treatment for Medical Condition

Client/Caregiver Involvement in Recovery Plan

Client Signature:	Date:
Caregiver Signature:	Date:
<i>This Recovery Plan has been discussed with the client and/or the caregiver, and the client/caregiver acknowledges and understands their involvement in the Plan as indicated by their signature above.</i>	
Client/Caregiver Was Given or Sent a Medication Support Client Plan:	Date:
Client/Caregiver Declined a Copy of the Medication Support Client Plan:	Date:
Client/Caregiver Refused to Sign the Medication Support Client Plan: See Progress Note(s) Dated: _____	Date:
Reason for Client/Caregiver Late Signature Date on the Medication Support Client Plan: See Progress Note(s) Dated: _____	Date:

DATE OF ENTRY:		PLAN START DATE:	
Date:	Provider Printed Name:	Provider Signature:	