## San Bernardino County Department of Behavioral Health MEDICATION SUPPORT SERVICES CLIENT PLAN

Page \_\_\_ of \_\_\_

"A partnership in wellness"

Diagnostic Symptoms and related impairments Diagnostic (Dx) Symptoms:					
Observable, measurable, functi	onal impairments re	lated to diagnos	stic symptoms:		
Client Driven Goals (Behavioral,	Measurable Objectives	with time frames	and quantifiable me	asures)	
To be achieved by	o be achieved by (plan end date or goal target date)				
1. Client will reduce/increase		from times per			
(circle one) (o to a goal of times p (frequency)	bservable, measurable	behavior)	(frequency)	(hr.,day,wk.,mo.)	
(frequency)	(hr,day,wk,mo)	(sustained for)	(S timos p	elf-report, observation, etc.)	
2. Client will reduce/increase(o	bservable, measurable Der /	behavior)	(frequency) as measured by	(hr.,day,wk.,mo.)	
to a goal of times p <i>(frequency)</i>	(hr,day,wk,mo)	(sustained for)	(s	elf-report, observation, etc.)	
(Also see MSS ID notes and order she	eet as part of the Plan fo	r MSS)			
Other (Describe): Interventions: Provide medication evaluation/pressure	rescriptions/monitorin	g as indicated:			
Provide medication evaluation/prescriptions/monitoring as indicated:     (appointment frequency)					
Provide supervision for case main		Coordinate with support system			
Educate patient on medication and		Psychosocial education			
Educate patient to appropriately	utilize community res	ources	Other:		
Encourage participation in other	treatment services:				
Mental Health Counseling	Alcohol and Drug Co	unseling 🗌 Trea	tment for Medical	Condition	
Plan Start Date:Pla extend beyond the end date of the general	an End Date: I Client Plan)	(for	clients receiving mult	tiple services, this date is not to	
Client*	Date	Parent/Gua	rdian <i>(if applicab</i> )	le) Date	
*If no signature, or late dated			Copy of Plan was given/sent to client (date)		
signature, see progress note dated: (date)		Copy of F	Plan offered, but was	declined by client	
Staff Signature Date	Printed Name	Staff Printed	Name and Title		
Physician's Signature	Date	Printed Nam	10		
Medication Support	NAME:				
San Bernardino C Department of Behav		CHART NO: DOB: PROGRAM:			
Confidential Patient Ir See W & I Code					
Revised 05/09 E					
	PROGRAM:				

**Clinical Practice**