Cornerstone Behavioral Healthcare
Substance Use Individual Treatment Plan

Client#

Client Name (Print):			DOB:
☐Initial	☐Review	☐Annual	
Identifying Problems:			
As Evidenced By:			
Diagnosis Primary:		Diagnosis Secondary:	
Goals/Objectives are measured by:	☐Self-Report	☐Clinician Observation	☐Other:

Long Term Goals	Objectives	Progress (please explain your answers)	Projected Date of Completion
1.			
2.			
3.			

Client#

Short Term Goals	Objectives	Progress (please explain your answers)	Projected Date of Completion
1.			
2.			
3.			

Provider Name	Type of Service	Frequency/Duration
	Therapy	Frequency: ☐weekly ☐bi-weekly ☐monthly ☐other: Duration: ☐1 hour ☐1 ½ hours ☐2 hours ☐other:
	Med Management	Frequency: ☐weekly ☐bi-weekly ☐monthly ☐other: Duration: ☐1/2 hour ☐other:
	Substance Abuse	Frequency: ☐weekly ☐bi-weekly ☐monthly ☐other: Duration: ☐1 hour ☐1 ½ hours ☐2 hours ☐other:

	Case Management	Frequency: ☐weekly ☐bi-weekly ☐monthly ☐other: Duration: ☐1 hour ☐1 ½ hours ☐2 hours ☐other:
	Medication Assisted Treatment	Frequency: ☐weekly ☐bi-weekly ☐monthly ☐other: Duration: ☐1 hour ☐1 ½ hours ☐2 hours ☐other:
	Other	Frequency: ☐weekly ☐bi-weekly ☐monthly ☐other: Duration: ☐1 hour ☐1 ½ hours ☐2 hours ☐other:

Physical Accommodations and Barriers: ☐**N/A** ☐**Yes- (**Please explain)

Stages of Change	**Risk Assessment**

Unmet needs please identify (e.g. dental provider, PCP, etc.): ☐**N/A**

Justification for not addressing unmet need: ☐**N/A** ☐**Unavailable** ☐**Yes- (**Please explain)

Discharge criteria is based on above measurements and:

Please document any referrals for services not directly provided by you

Referral made to:

Referral made to:

Risk and Benefits Statement

I have developed my ITP and Safety Plan with my provider. We have reviewed the risks and benefits associated with these plans. I have been offered a copy of these plans and agree to work towards these goals.
☐**Yes** ☐**No (If no, please explain):**

Participant Names & Signatures	**Signature Dates**
Client:	
Parent/Guardian:	
Other Participant(s):	
Provider:	
Supervisor:	
Is this Treatment Plan Review late (and still in effect)? ☐**No** ☐**Yes**	
If yes, please explain why it was late:	