Cornerstone Behavioral Healthcare

MAT Individualized Treatment Plan

Client#

Client Name (Print):	DOB:

☐Initial	☐Update	☐Annual
Participants Involved in ITP development: Clinician, Client	☐**Other (please identify):**	
Identifying Problems:		
As Evidenced By:		

Primary Diagnosis:	Secondary Diagnosis:

Assessment (check applicable)

☐Provider observation of effectiveness, symptoms and side effects
☐Report effectiveness, symptoms and side effects by client
☐Report effectiveness, symptoms and side effects by guardian
☐Report effectiveness, symptoms and side effects by other

Long Term Goals	Objectives	Progress (please explain your answers)	Projected Date of Completion
1. To manage my symptoms and improve the quality of my life by using medications as my provider recommends that are safe and effective for me.			
2. To support my provider in coordination of my care with other providers as identified by my consent.			
3.			

Client#

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Short Term Goals	Objectives	Progress (please explain your answers)	Projected Date of Completion
1. I will take my medication as prescribed by my provider.			
2. I will not change or discontinue my medication unless I have spoken with my provider.			
3. I will work closely with my provider to manage the side effects of my medication.			

Stable on medication so that Primary Care Provider can prescribe:	☐Yes ☐No

Provider Name	Treatment Modality	Frequency/Duration
	Individual Therapy	☐weekly ☐bi-weekly ☐monthly ☐other:
	Med Management	☐weekly ☐bi-weekly ☐monthly ☐other:
	PCP (complete releases if applicable)	☐weekly ☐bi-weekly ☐monthly ☐other:
	Group Therapy	☐weekly ☐bi-weekly ☐monthly ☐other:
	Pain/Substance Clinic	☐weekly ☐bi-weekly ☐monthly ☐other:
	Other:	☐weekly ☐bi-weekly ☐monthly ☐other:

Physical Accommodations and Barriers: ☐N/A (If yes, please explain)

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Risk Assessment (1=Low, 10=High please explain your answer):

Client's strengths:

Client's weakness:

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 are based on above measurements and: (check applicable)

☐ Client has met all treatment goals.	☐ Client not available.
☐ Client non-compliant with medications.	☐Client moved out of the service area.

Address/phone change: ☐Yes ☐No If yes, update:

Reviewed Crisis Plan: ☐Yes ☐No

AMHI class member: ☐Yes ☐No (If yes, answer the following)

- Advance Psychiatric Directive (AMHI only) ☐Yes ☐No (If yes, answer the following)
- Was the form reviewed? ☐Yes ☐No

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	**Date**
Client:	
Parent/Guardian (if applicable):	
Other Participant(s):	
Provider:	
Supervisor (if applicable):	

Is this Treatment Plan Review late (and still in effect)? ☐No ☐Yes

If yes, please provide the reason for it being late:

☐Client cancellations/no shows ☐Client did not return for services

☐Infrequency of client visits ☐Other:

☐Provider error (please explain):