Patient Chart # _____

TREATMENT PLAN/ PLAN REVIEW/ DISCHARGE PLAN

Patient Name:_____D.O.B.:_____Est. Discharge Date: _____

After Care Plan: Patient/Family's expectation concerning treatment outcome, community resource referrals, educational activities, and/or other support services to withstand improvements achieved during treatment:

_____

_____

_____

Responsible Behavioral Staff: _____

I, the patient or the patient's guardian reviewed and agreed to participate in the interventions identified in the Individualized Treatment Plan that is in Intecelle Inc. electronic records system (Open EMR). **I HAVE ALSO RECEIVED A COPY OF SAID TREATMENT PLAN FOR MY RECORDS.**

Furthermore, the services can be expected to improve the client's condition and functional level which cannot be improved in a less restrictive or less costly level of care.

Plan Effective Date:_____

☐ **Patient** ☐ **Guardian Signature:** _____ **Date:** _____

Clinician Signature & Credentials: _____ **Date:** _____

Supervisor/Reviewer Signature & Credentials: _____ **Date:** _____

Addt'l Team Mbr. Signature & Credentials: _____ **Date:** _____

As the treating psychiatrist and/or licensed clinician for the above referenced patient; I hereby certify this patient meets the eligibility criteria and needs the behavioral health services as outlined in the Individualized Treatment Plan.

I additionally certify the specific treatment services herein prescribed for the patient in this Treatment Plan is medically necessary and appropriate to the patient diagnosis and treatment will start from the date of admission. Review of this treatment plan will occur at a minimum of every six (6) months.

Community Behavioral Health Services for Adults & Children
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