TREATMENT PLAN

Client's Name:

Date of Birth:

Client's Address:

Mental Health Facility:

Mental Health Facility Address:

Director/Deputy Director of Community Treatment:

Treating Doctor/Psychiatrist:

Psychiatric Case Manager:

Date:

GOALS OF TREATMENT

(Set out specific goals relevant to the client including a brief description of how the client will be supported to pursue their own recovery)

-
-
-

RESPONSIBILITIES OF THE *(insert name of Mental Health Facility)*

(Set out an outline of the proposed treatment, counselling, management, rehabilitation or other services to be provided by the Mental Health Facility to meet the needs and circumstances of the client)*.*

-
-
-

***(insert client's name)*'S <u>OBLIGATIONS</u> (include as required)**

1. ***(insert client's name***) must take the medication as prescribed and/or varied by ***(insert name of treating doctor)*** or delegate.

   Current Medication:

Medication	**Dose**	**Oral/Intramuscular**	**Frequency**

2. ***(insert client's name***) must attend reviews with ***(insert name of treating doctor)*** or delegate at least ***(insert frequency)***.
3. ***(insert client's name***) must meet with ***(insert case manager name)*** or delegate at least ***(insert frequency)***.
4. The frequency, place or timing of appointments between ***(insert client's name***) and the case manager and treating doctor or delegates may be changed by the case manager or treating doctor.
5. Appointments for review and/or medication may occur at ***(insert client's name)***'s home if he/she consents and the case manager or treating doctor agrees to home visits. Otherwise, ***(insert client's name***) must attend appointments for review and medication at ***(insert name and address of service)***.

Other possible conditions to be included follow. These are examples only and not exhaustive. Please refer to the Tribunal's Guidelines for Community Treatment Order Applications for further information about the scope of treatment plans and the types of conditions which can be included.

6. ***(insert client's name)*** is required to have blood tests as requested by the case manager/treating doctor/psychiatrist no more than ***(insert maximum number)*** times in (***insert number of months)*** months ***(OR as clinically indicated).***

7. ***(insert client's name)*** is required ***(or encouraged)*** to comply with requests to provide a urine sample for the conduct of urine drug screens no more than ***(insert maximum number)*** times ***(insert frequency)*** as requested by the case manager/ treating doctor/ psychiatrist.

8. ***insert client's name)*** is encouraged ***(or required)*** to attend drug and alcohol counselling ***(insert maximum number)*** times ***(insert frequency)*** as requested by the case manager/ treating doctor/ psychiatrist.

9. ***(insert any additional clauses relevant to the specific needs of the client)***

Signed and dated:

Case Manager or Delegate	Director (or Deputy Director) of Community Treatment
(Print Name)	(Print Name)
Date:	Date: