Communication Skills Treatment Plan

Patient information	
Name:	**Phone number:**
Age:	**Date of birth:**
Sex:	**Date of consultation:**
Diagnosis:	
Symptoms	
[List specific symptoms]	
Assessment results	
[Document any relevant results and criteria that support the diagnosis]	
Treatment goals	
Short-term goals	**Long-term goals**
Intervention/s	
[Detail what interventions are planned for the patient]	

Recommended medication (if applicable)	
[List down what medication is recommended for the patient]	
Progress notes	
Client signature:	**Date**:
Healthcare provider's information	
Name:	
ID number:	
Contact details:	
Signature:	