Disruptive Mood Dysregulation Disorder Treatment Plan

Patient Information	
Name:	Date of Birth:
Patient ID:	Date of Assessment:
Referring Physician:	
Diagnostic Summary	
Diagnosis:	
Date of Diagnosis:	
Criteria Met:	
Treatment Goals	
1. Reduce Frequency of Temper Outbursts:	
2. Improve Mood Regulation:	
3. Enhance Coping Skills:	
4. Improve Functional Outcomes:	

5. Support Family and Caregivers:

Interventions

Psychotherapy

- **CBT:**

  Frequency and Duration:
- **PCIT:**

  Frequency and Duration:
- **DBT-A:**

  Frequency and Duration:

Medication Management (if applicable)

Mood Stabilizers/Antidepressants:

Educational and School-Based Interventions

IEP Coordination:

Details:

Social Skills Group

Frequency and Duration:

Family Support and Education

- **Family Therapy:**

  Frequency and Duration:
- **Psychoeducation Workshops:**

  Frequency and Duration:

Monitoring and Evaluation
Follow-Up Appointments
Frequency and Purpose:
Behavioral Observation and Reports
Tools and Respondents:
Medication Review
Frequency and Process:
Expected Outcomes
Short-Term:
Long-Term:
Signature of Treatment Provider
Date:
Consent by Patient / Guardian
I, the undersigned, acknowledge understanding the treatment plan and consent to the proposed interventions.
Patient / Guardian Signature
Date: