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:
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: