Integrated Treatment Plan

Client Information
Name:
ID Number:
Date of Birth:
Date of Initial Assessment:
Plan Creation Date:
Primary Therapist/Care Coordinator:
Referral Information
Referred by:
Reason for Referral:
Previous Interventions/Treatments:
Presenting Problem(s)
Primary Concerns:
Secondary Concerns:
Diagnostic Summary
Mental Health Diagnosis:
DSM-5 Code:
Description:

Substance Use Diagnosis:
DSM-5 Code:
Description:
Physical Health Diagnosis:
ICD-10 Code:
Description:
Treatment Goals and Objectives
Objective 1:
Intervention:
Responsible Party:
Timeline:
Objective 2:
Intervention:
Responsible Party:
Timeline:
Treatment Modalities and Interventions
Psychotherapy (type, frequency, duration):

Pharmacotherapy (medications, dosages, monitoring):
Substance Use Treatment(detoxification, rehabilitation programs):
Physical Health Management (primary care coordination, physical therapy):
Social Support Services (housing, employment, community resources):
Client Strengths and Resources
Personal Strengths:
Support Systems:
Risk Management Plan
Identified Risks:
Management Strategies:

Consent for Treatment		
Consent Obtained:	Yes	No
Date of Consent:		
Review and Adjustment Schedule		
Review Dates:		
Criteria for Adjustment:		
Signatures		
Primary Therapist/Care Coordinator:		
Date:		
Client/Guardian:		
Date:		