Treatment Plan for Substance Abuse

Patient Information

First Name	Last Name	Date of Birth	Patient Identifier (If known)
Haley	Rowan	02/15/1993	ABC123
Gender	**Preferred Pronouns**	**Email**	**Contact Number**
F	She/Her	hrowan@sample.co	555-5555

Diagnosis

Problem	Indicators	ICD-10 Code (If Applicable)	Note
Alcohol dependence with alcohol-induced mood disorder	3 DUI's in past 18 months, unable to regulate alcohol consumption	F10.24	

Medication(s)

Medication Name	Dose	Frequency	Date Started	Indication
Naltrexone (Trexan)	50mg	Once Daily	02/01/2023	Alcohol abuse

Goals

Short Term Goals	Objectives	Interventions + Responsible Person(s)	Target Date for Completion
Attend recovery meetings regularly	Attend a meeting at least once weekly for six months	Mike Long (AA sponsor)	08/02/2023
Create positive, healing space in home	Discard all alcohol related items. Delete contacts of unsupportive people	Ellie Rowan (sister)	02/06/23
Work with therapist to improve coping skills and mental resilience	See therapist weekly for four months	Emma Baron (therapist)	06/02/2023

Notes

AA referral sent 01/30/2023

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Goals (Continued)

Long Term Goals	Objectives	Interventions + Responsible Person(s)	Target Date for Completion
Restore relationship with parents	Take kids to spend time with their grandparents every other weekend.	Martha Rowan (Mother)	Ongoing
Be able to go out with friends without having a drink	Find new group of friends through a new non-alcohol related hobby	Haley Rowan	02/01/2024

Notes

Plan for Coordination of Care

AA sponsor given my contact number.

I will coordinate with Emma (therapist) and Haley to monitor Haley's progress.

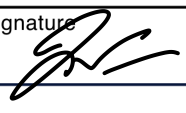
Haley and her family will have weekly dinner meetings together.

Plan for Review of Treatment Process

I will see Haley in two weeks time to see how her first therapy session and AA meetings went and see how she is tracking. First review of treatment plan set for one month's time. Review of naltrexone in six week's time.

Additional Notes

I am confident in Haley's ability to make a full and successful recovery, and am happy to see her caring support system who will help her through.

Patient Name		Signature	Date
Haley Rowan			02/01/2023
Patient's Representative (if patient unable to sign) Name		Signature	Date
Provider Name	Designation	Signature	Date
Dr Jo Steele	Family Doctor		02/01/2023