|  |  |
| --- | --- |
| **Logo  Description automatically generated** | **NSW Health**  Choose LHD |

**TREATMENT PLAN**

|  |  |
| --- | --- |
| **Mental Health Facility:** |  |
| **Facility Address:** |  |
| **Facility Telephone:** |  |
| **Client Name:** |  |
| **Date of birth:** |  |
| **Client Address:** |  |
| **Director/**  **Deputy Director of Community Treatment** |  |
| **Treating Doctor/**  **Psychiatrist:** |  |
| **Psychiatric Case Manager:** |  |

# Goals of Treatment

1. Set out specific goals relevant to the client.
2. Describe how the client will be supported in pursuing their recovery.

# Responsibilities of [Insert MHF Name]

1. Set out an outline of the proposed treatment plan.
2. Include counselling, management, rehabilitation and/or other services which will be provided by the Mental Health Facility.

# Responsibilities of [Insert Client Name]

1. [Insert Client’s Name] must take medication as prescribed and/or varied by the Treating Doctor/Psychiatrist or delegate.
2. Current Medication:

|  |  |  |  |
| --- | --- | --- | --- |
| Medication | Dose | Oral / Intramuscular | Frequency |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |

1. [Insert Client’s Name] must attend reviews with [Insert Treating Doctor/Psychiatrist’s Name] or delegate at least [Insert Frequency].
2. [Insert Client’s Name] must attend reviews with [Insert Psychiatric Case Manager’s Name] or delegate at least [Insert Frequency].
3. The frequency, place or timing of appointments with [Insert Treating Doctor/Psychiatrist’s Name], [Insert Psychiatric Case Manager’s Name] or their delegates may be changed by the Psychiatric Case Manager or by the Treating Doctor/Psychiatrist.
4. Appointments for review and/or medication may occur at [Insert Client Name]’s home if they consent and the parties agree. Otherwise, [Insert Client Name] must attend appointments for review and medication at [Insert Mental Health Facility and address].

# Other Possible Conditions **[Optional – please delete any or all options if not applicable]**

1. [Insert Client Name] is required to have blood tests for the purpose of [Insert purpose of test] as requested by the Case Manager or the Treating Doctor/Psychiatrist, no more than [Insert maximum number] times in [Insert number of months] or as clinically indicated.
2. [Insert Client Name] is required to comply with requests to provide a urine sample for the purpose of drug screening no more than [Insert maximum number] times in [Insert number of months] or as clinically indicated.
3. [Insert Client Name] is required to attend Drug and Alcohol Counselling no more than [Insert maximum number] times in [Insert number of months].
4. [Insert any other clause relevant to the needs of the client.]

# Signature

|  |  |  |  |
| --- | --- | --- | --- |
| Signature | Name | Position | Date |
|  | [Insert Psychiatric Case Manager’s Name] | Case Manager (or delegate) | [Insert Date] |
|  | [Insert Director/Deputy Director of Community Treatment’s Name] | Director / Deputy Director of Community Treatment | [Insert Date] |