McLAREN FLINT

Behavioral Health
Individual Plan of Service: Treatment Review

Initial Date of Individual Plan of Service: ________________ Review Date: __________________

Problem Statement # (1) ____

<table>
<tr><td colspan="3">Objective 1:</td></tr>
<tr><td rowspan="3">Modification:</td><td colspan="2">❑ Continued
❑ Met
❑ Modified</td></tr>
<tr><td>Date</td><td>Staff Initials</td></tr>
<tr><td></td><td></td></tr>
<tr><td colspan="3">Objective 2:</td></tr>
<tr><td rowspan="3">Modification:</td><td colspan="2">❑ Continued
❑ Met
❑ Modified</td></tr>
<tr><td>Date</td><td>Staff Initials</td></tr>
<tr><td></td><td></td></tr>
</table>

700a

PT.

MR.#/P.M.

DR.

McLAREN FLINT

Behavioral Health

Individual Plan of Service: Treatment Review

Problem Statement # (2) ____

Objective 1:		
Modification:	❑ Continued ❑ Met ❑ Modified	
	Date	Staff Initials
Objective 2:		
Modification:	❑ Continued ❑ Met ❑ Modified	
	Date	Staff Initials

PT.

MR.#/P.M.

DR.

McLAREN FLINT

Behavioral Health
Individual Plan of Service: Treatment Review

Problem Statement # (3) ____Medically Stable – Altered Health Status________________

AS EVIDENCED BY:

Objective 1:

Modification:

- ❑ Continued
- ❑ Met
- ❑ Modified

Date	Staff Initials

PT.

MR.#/P.M.

DR.

McLAREN FLINT

Behavioral Health
Individual Plan of Service: Treatment Review

Barriers:

Restrictions:
__ No __Yes
Explain:____
____
____
____

Signatures of Persons Participating in Review of Treatment Plan

Signature	Date	Title

Check all that apply:

- ❑ Client/guardian received copy of this plan __Client/guardian refused copy of this plan
- ❑ Client/guardian wants Primary Care Physician to receive a copy of this plan

  Name of Primary Care Physician: ________________________________

- ❑ Client/guardian wants outpatient therapist to receive a copy of this plan

  Name of Outpatient Therapist: __________________________________

____
Treatment Plan Initiated by: Staff Signature Time/Date

PT.

MR.#/P.M.

DR.