Treatment Plan Review

Time of Review: _____ 30 day _____ 60 day _____ 90 day _____ Non-Routine Number of visits this period _____

Current Primary DX: _____ Code: _____ Current GAF: _____

I. Progress/lack of progress toward treatment plan goals/objectives: _____

Rate Overall Progress: ( )Significant ( )Moderate ( )Slight ( )No change ( )Worsening ( )In denial

II. Problems/needs identified since last review: (describe referrals, etc., as appropriate: if no new problems, state none):

III. Justification for continued treatment: _____

IV. Patient's input regarding his/her progress: (use patient's own words when possible): _____

V. Based on I-IV above, are changes/additions necessary on the treatment plan?_____No_____Yes (Revise or add to treatment plan)

VI. Estimated date of discharge or number of sessions to discharge: _____

VII. Change in diagnosis:_____No_____Yes:_____

Treatment Team Signatures:

_____ Therapist

_____ Patient (optional)

_____ Psychiatrist/Physician

_____ Other Team Member: (if applicable)

Comments by Team Memebers (if any): _____

Client Name: _____

Client ID: _____ Date: _____