



<b>Organization Name:</b>	<b>Program Name:</b>	<b>Date:</b>
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<b>Individual's Name</b> (First / MI / Last):	<b>Record #:</b>	<b>DOB:</b>
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<b>Date Plan Initiated:</b>	<b>Target Completion Date:</b>
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**Adjusted Target Date:** As per IAP Review/Revision form or Progress Note dated:

**Desired Outcomes in the Individual's words (Required for CARF & OMH Parts 594/595):**

**Goals and Objectives:**

1. Maximize individual's independence by reducing/managing disabling psychiatric symptoms.  
 Linked to Prioritized Assessed Need # \_\_\_\_\_ from form dated \_\_\_\_:  CA  CA Update  RFA  Psych Eval.  Other:

- A. Individual's current signs and symptoms will be managed through the use of appropriate psychiatric medications.
- B. Individual will assist medical staff in monitoring side effects through appropriate lab work, monitoring of vital signs, and direct observation/reporting.
- C. Individual will be able to list medications, uses, benefits and side effects, including the impact of co-morbid medical conditions.
- D. Individual will take medications as prescribed.
- E. Individual will understand and manage lifestyle activities that may increase or decrease symptoms or medication side effects
- F. Other (Specify Objective):

2. Maintain chemical dependence recovery for improved mental and physical health.  
 Linked to Prioritized Assessed Need # \_\_\_\_\_ from form dated \_\_\_\_:  CA  CA Update  RFA  Psych Eval.  Other:

- A. Individual's current signs and symptoms will be managed through the use of appropriate psychiatric medications.
- B. Individual will assist medical staff in monitoring side effects through appropriate lab work, monitoring of vital signs, and direct observation/reporting.
- C. Individual will be able to list medications, uses, benefits and side effects, including the impact of co-morbid medical conditions.
- D. Individual will take medications as prescribed.
- E. Individual will understand and manage lifestyle activities that may increase or decrease symptoms or medication side effects
- F. Other (Specify Objective):

3. Reduce (or Discontinue) Medication Regime.  
 Linked to Prioritized Assessed Need # \_\_\_\_\_ from form dated \_\_\_\_:  CA  CA Update  RFA  Psych Eval.  Other:

- A. Individual's current signs and symptoms will be managed through the use of appropriate psychiatric medications.
- B. Individual will assist medical staff in monitoring side effects through appropriate lab work, monitoring of vital signs, and direct observation/reporting.
- C. Individual will be able to list medications, uses, benefits and side effects, including the impact of co-morbid medical conditions.
- D. Individual will take medications as prescribed.
- E. Individual will understand and manage lifestyle activities that may increase or decrease symptoms or medication side effects
- F. Other (Specify Objective):

4. Other:  
 Linked to Prioritized Assessed Need # \_\_\_\_\_ from form dated \_\_\_\_:  CA  CA Update  RFA  Psych Eval.  Other:

- A. Individual's current signs and symptoms will be managed through the use of appropriate psychiatric medications.
- B. Individual will assist medical staff in monitoring side effects through appropriate lab work, monitoring of vital signs, and direct observation/reporting.
- C. Individual will be able to list medications, uses, benefits and side effects, including the impact of co-morbid medical conditions.
- D. Individual will take medications as prescribed.
- E. Individual will understand and manage lifestyle activities that may increase or decrease symptoms or medication side effects
- F. Other (Specify Objective):

**Individual's Strengths and Skills that will be Utilized to Meet This Goal:**

**Description of Outside Services, Supports, and Plan of Coordination Needed to Meet this Goal:**



**Individualized Action Plan: Psychopharmacology**

Revision Date: 11-1-12

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<b>Individual's Name</b> (First / MI / Last):	<b>Record #:</b>	<b>DOB:</b>
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Therapeutic Intervention Methods	Provider	Frequency	Duration
<input type="checkbox"/> Medication Management	<input type="checkbox"/> MD/DO <input type="checkbox"/> RPA <input type="checkbox"/> NP	<input type="checkbox"/> Weekly <input type="checkbox"/> Other (list): <input type="checkbox"/> Monthly <input type="checkbox"/> Quarterly	<input type="checkbox"/> 1 Month <input type="checkbox"/> 9 Months <input type="checkbox"/> 3 Months <input type="checkbox"/> 1 Year <input type="checkbox"/> 6 Months <input type="checkbox"/> Other:
<input type="checkbox"/> Medication Education / Symptom / Illness Management	<input type="checkbox"/> MD/DO <input type="checkbox"/> RPA <input type="checkbox"/> RN <input type="checkbox"/> NP <input type="checkbox"/> Other (list):	<input type="checkbox"/> Weekly <input type="checkbox"/> Other (list): <input type="checkbox"/> Monthly <input type="checkbox"/> Quarterly	<input type="checkbox"/> 1 Month <input type="checkbox"/> 9 Months <input type="checkbox"/> 3 Months <input type="checkbox"/> 1 Year <input type="checkbox"/> 6 Months <input type="checkbox"/> Other:
<input type="checkbox"/> Injections	<input type="checkbox"/> MD/DO <input type="checkbox"/> RPA <input type="checkbox"/> RN <input type="checkbox"/> NP <input type="checkbox"/> Other (list):	<input type="checkbox"/> Weekly <input type="checkbox"/> Other (list): <input type="checkbox"/> Monthly <input type="checkbox"/> Quarterly	<input type="checkbox"/> 1 Month <input type="checkbox"/> 9 Months <input type="checkbox"/> 3 Months <input type="checkbox"/> 1 Year <input type="checkbox"/> 6 Months <input type="checkbox"/> Other:
<input type="checkbox"/> Physical Assessment (Vital signs, AIMS, weight, etc).	<input type="checkbox"/> MD/DO <input type="checkbox"/> RPA <input type="checkbox"/> RN <input type="checkbox"/> NP <input type="checkbox"/> Other (list):	<input type="checkbox"/> Weekly <input type="checkbox"/> Other (list): <input type="checkbox"/> Monthly <input type="checkbox"/> Quarterly	<input type="checkbox"/> 1 Month <input type="checkbox"/> 9 Months <input type="checkbox"/> 3 Months <input type="checkbox"/> 1 Year <input type="checkbox"/> 6 Months <input type="checkbox"/> Other:
<input type="checkbox"/> Coordination	<input type="checkbox"/> MD/DO <input type="checkbox"/> RPA <input type="checkbox"/> RN <input type="checkbox"/> NP <input type="checkbox"/> Other (list):	<input type="checkbox"/> Weekly <input type="checkbox"/> Other (list): <input type="checkbox"/> Monthly <input type="checkbox"/> Quarterly	<input type="checkbox"/> 1 Month <input type="checkbox"/> 9 Months <input type="checkbox"/> 3 Months <input type="checkbox"/> 1 Year <input type="checkbox"/> 6 Months <input type="checkbox"/> Other:
<input type="checkbox"/> Other	<input type="checkbox"/> MD/DO <input type="checkbox"/> RPA <input type="checkbox"/> RN <input type="checkbox"/> NP <input type="checkbox"/> Other (list):		<input type="checkbox"/> 1 Month <input type="checkbox"/> 9 Months <input type="checkbox"/> 3 Months <input type="checkbox"/> 1 Year <input type="checkbox"/> 6 Months <input type="checkbox"/> Other:

**Referrals/Additional Evaluations**  None required  
 Physical Assessment  Substance Abuse Assessment  Neurological Consult  Psychological Testing  Neuropsych Testing  
 Nutritional/Dietician  Other (list):

Explained rationale, benefits, risks, and treatment alternatives to/for the Individual?  Yes  No

Transition/Discharge Criteria	For COA Programs Only: Estimated Length of Treatment and Stay:
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**Criteria** - How will the provider/individual/guardian know that care has been completed or that a transition to a lower level of care is warranted? (For OMH Housing Programs for Children and Adolescents, Include a description of the skills needed to return home or into the community / Check All that Apply):

Reduction in symptoms as evidenced by:

Attainment of higher level of functioning as evidenced by:

Treatment is no longer medically necessary as evidenced by:

Other:

If the Individual refuses any part of the plan, describe reason and plan for continuation of services:

Individual has participated in the development of this plan  Yes  No, provide reason:

Other(s) \_\_\_\_\_ participated in the development of this plan  Yes  No, If Yes, List Names

Individual Served:	Individual Served Signature	Date:
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Parent/Guardian Name <input type="checkbox"/> (N/A):	Parent/Guardian Signature:	Date:
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If lacking signature of Individual/Parent/Guardian, provide reason for non-participation:

NPP - Print Name/Credentials <input type="checkbox"/> (N/A):	NPP Signature:	Date:
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Psychiatrist/MD/DO - Print Name/Credentials <input type="checkbox"/> (N/A):	Psychiatrist/MD/DO Signature:	Date:
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**If Applicable, Additional Staff Sign Below**

Print Staff Name/Credentials <input type="checkbox"/> (N/A):	Staff Signature:	Date:
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Print Staff Name/Credentials <input type="checkbox"/> (N/A):	Staff Signature:	Date:
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