

Individual Plan of Care Master Plan (Within 72 hours of admission)

Patient Name _____
 Admission Date _____ IPC Date _____
 Level of Care Acute RTC

Diagnosis:

Axis I: _____

Axis II: _____

Axis II: _____

_____ (FSIQ _____ or adaptive functioning _____)

Axis IV: _____

Axis V: Current GAF _____

Patient's strengths/limitations that will be considered in resolution of the problems/needs

Strength/Limitation	Poor	Fair	Good	Excellent
Social Skills				
Receptive language skills				
Expressive language skills				
Capacity for Independence				
Family Stability				
School/Job Stability				
Capacity to learn				
Involvement in hobbies/leisure activities				
Spirituality				
Capacity for insight				
Ability to read				
Ability to write				
Other:				

Legal (explain): _____

Current Medications: _____

Developmental Concerns: _____

Cultural Concerns: _____

Contra-indications for physical management and/or seclusion: _____

Problem/Needs List

Patient Name _____ Date _____

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Does patient have a history of: (Check all that apply)

Date Identified	Date Identified	Date Identified
<input type="checkbox"/> Losing control	<input type="checkbox"/> Feeling unsafe	<input type="checkbox"/> Restraint or seclusion
<input type="checkbox"/> Assaultive	<input type="checkbox"/> History of trauma	<input type="checkbox"/> Self injurious behavior
<input type="checkbox"/> Violence	<input type="checkbox"/> Physical or sexual abuse	<input type="checkbox"/>
<input type="checkbox"/> Medical conditions or physical disability	<input type="checkbox"/>	<input type="checkbox"/>

Describe: _____

Triggers contributing to escalation:

What are some things that make it more difficult for the patient when they are already upset? Are there particular "triggers" that will cause the patient to escalate?

Date Identified	Date Identified
<input type="checkbox"/> being touched	<input type="checkbox"/> being isolated
<input type="checkbox"/> people in uniform	<input type="checkbox"/> time of year (when?)
<input type="checkbox"/> particular time of day (when?)	<input type="checkbox"/> yelling
<input type="checkbox"/> loud noise	<input type="checkbox"/> being around men
<input type="checkbox"/> not having control/input (explain)	<input type="checkbox"/> being around women
<input type="checkbox"/> not having personal space	<input type="checkbox"/> other _____

Describe _____

Coping skills techniques that patient uses to regain behavioral control:

It is important to consider what things might help patient feel better when they have been having a hard time and think they might lose control. Check all that apply.

Date Identified	Date Identified
<input type="checkbox"/> voluntary time out in quiet room	<input type="checkbox"/> reading
<input type="checkbox"/> sitting by the nurses station	<input type="checkbox"/> watching TV
<input type="checkbox"/> talking with another patient	<input type="checkbox"/> pacing the halls
<input type="checkbox"/> talking with male staff	<input type="checkbox"/> talking with female staff
<input type="checkbox"/> writing in a journal	<input type="checkbox"/> calling a friend
<input type="checkbox"/> deep breathing/relaxation	<input type="checkbox"/> exercise
<input type="checkbox"/> lying down with cold face cloth	<input type="checkbox"/> drawing
<input type="checkbox"/> wrapping in a blanket	<input type="checkbox"/> putting hands under cold water or holding ice cubes
<input type="checkbox"/> taking a shower	<input type="checkbox"/> listening to music
<input type="checkbox"/> talking with parent	<input type="checkbox"/> other _____

If patient becomes upset or is in danger of hurting self or someone else, what interventions have been effective? Preference in the event this would become necessary:

Date Identified	Date Identified
<input type="checkbox"/> quiet room	<input type="checkbox"/> other _____
<input type="checkbox"/> open door separation from community milieu	

Patient Name _____ **Date** _____

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Problem # _____ **Date Identified:** _____

As evidenced by: _____

Long Term Goal (Must be measurable) _____

Short term goals/objectives:

Objective 1: _____

Objective 2: _____

Interventions to accomplish objectives:

	Frequency	Staff name/ Title
Physician _____ _____ _____		
Clinical _____ _____ _____		
Nursing _____ _____ _____		
Activities Therapy _____ _____		
Therapeutic Milieu Management _____ _____ _____		
Education _____ _____		

Family expectations: Family therapy ____ x _____, visitations ____ x _____, telephone calls ____ x _____. Barriers to participation: _____

Discharge Planning: _____ Estimated Date of Discharge _____

Patient Name _____ Date _____

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Discharge Criteria: _____

Patient to return to:

- Home _____
- Therapeutic Foster Home _____
- Foster Home _____
- Nursing Home _____
- Room & Board _____
- Shelter _____
- Group Home _____
- Detention _____
- Other _____

Referrals for follow up care by:

Appointment time & date

- Psychiatrist _____
- Psychologist/Counselor _____
- Extended Inpatient treatment @ _____
- Outpatient treatment _____
- Primary Physician _____
- School Program @ _____
- Case Management _____
- Financial _____
- Employment/Vocational _____
- Temporary sponsor _____
- Medical _____
- Other _____

I was involved in the development of this treatment plan with a qualified treatment professional and have been given the opportunity to ask any questions and make suggestions.

I understand the treatment plan contents.

Response: Agreed Disagreed Comment _____

Signature of Patient: _____ date _____

Response: Agreed Disagreed Comment _____

Signature of Parent/Guardian _____ date _____

Reviewed with Guardian via telephone by _____ on (date) _____

Left message with

_____ on(date) _____ time _____

Faxed/mailed copy to _____ on(date) _____ time _____

Treatment Team Signatures (including credentials)

Physician _____ Date _____

MHP _____ Date _____

Registered Nurse _____ Date _____

Therapist (if applicable) _____ Date _____

Other _____ Date _____

Other _____ Date _____

Other _____ Date _____

Utilization Review Manager (optional) _____ Date _____

Patient Name _____ **Date** _____

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