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|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------|---------------------------------------------------------------------------------|
| <b>Recovery Phase</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | Clinician:                                           |                                                                                 |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | Client:                                              |                                                                                 |
| Date:      -      -<br>d      m      yr                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                      | Present:<br><input type="checkbox"/> Client <input type="checkbox"/> Family:<br><input type="checkbox"/> Other:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                      | Location:<br><input type="checkbox"/> Office<br><input type="checkbox"/> Other: |
| <b>Client</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | <b>Family</b>                        | <b>Topics</b><br>See education/psychosocial intervention section for overviews and handouts.<br><br><input type="checkbox"/> Psychosis<br><input type="checkbox"/> Etiology<br><input type="checkbox"/> Early Intervention<br><input type="checkbox"/> Medication<br><input type="checkbox"/> Psychosocial Treatments<br><input type="checkbox"/> Stress Management<br><input type="checkbox"/> Relapse Prevention - develop prevention plan as early on as possible<br><input type="checkbox"/> Social Functioning<br><input type="checkbox"/> Lifestyle<br><input type="checkbox"/> Goal Setting<br><input type="checkbox"/> Problem Solving<br><input type="checkbox"/> Drugs and Alcohol<br><input type="checkbox"/> Persistent Symptoms<br><input type="checkbox"/> Other (please indicate): _____ | <b>Progress Notes</b>                                |                                                                                 |
| <input type="checkbox"/> <b>Individualized Care and Reintegration</b><br>• Document:<br><input type="checkbox"/> Progress made<br><input type="checkbox"/> Obstacles encountered<br><input type="checkbox"/> Revisions to individualized care or reintegration plans                                                                                                                                                                                                                                                                 |                                      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                      |                                                                                 |
| <input type="checkbox"/> <b>Ongoing Assessment</b><br>• At least every 3 months:<br><input type="checkbox"/> Assessment update completed using Update Template<br><input type="checkbox"/> 2-Com completed by client<br><input type="checkbox"/> Assess family impact and well-being<br><input type="checkbox"/> Review relapse prevention plan                                                                                                                                                                                      |                                      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                      |                                                                                 |
| <input type="checkbox"/> <b>Other Care</b><br>• Maintain regular contact with:<br><input type="checkbox"/> General physician<br><input type="checkbox"/> Other care providers<br>• Provide based on need or readiness<br><input type="checkbox"/> Referrals for other services<br><input type="checkbox"/> Groups for client<br><input type="checkbox"/> Groups for family<br>• If prolonged recovery is suspected<br><input type="checkbox"/> Consult with psychiatrist<br><input type="checkbox"/> Document plans to change course |                                      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                      |                                                                                 |
| <b>Please assess the following for every visit. Describe any changes or problems in notes.</b>                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                      |                                                                                 |
| <b>Mental Status</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | <input type="checkbox"/> no change   | <input type="checkbox"/> improvement                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | <input type="checkbox"/> deterioration               |                                                                                 |
| <b>Functioning</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | <input type="checkbox"/> no change   | <input type="checkbox"/> improvement                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | <input type="checkbox"/> deterioration               |                                                                                 |
| <b>Stress</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | <input type="checkbox"/> no change   | <input type="checkbox"/> diminished stress                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | <input type="checkbox"/> increased stress/life event |                                                                                 |
| <b>Medication</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | <input type="checkbox"/> no problems | <input type="checkbox"/> side effects                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | <input type="checkbox"/> adherence issues            |                                                                                 |