

# Company Name

Address  
City, State Zip

## Treatment Plan For Outpatient Mental Health

Number of additional sessions being requested \_\_\_\_\_. Beginning \_\_\_\_\_.

Diagnosis: I:

II:

III:

IX:

Areas of functional impairment include: \_\_\_\_\_  
\_\_\_\_\_

Client's presenting symptoms that support his/her diagnosis include: \_\_\_\_\_  
\_\_\_\_\_

If the client is 18 years of age or under, are the parents involved in treatment? \_\_\_\_ YES \_\_\_\_ NO

if no, explain \_\_\_\_\_

Continued treatment plan includes: \_\_\_\_\_

Current medications include: \_\_\_\_\_

Therapeutic Goals:

a. \_\_\_\_\_

b. \_\_\_\_\_

c. \_\_\_\_\_

Goal attainment is being measured by \_\_\_\_\_  
\_\_\_\_\_

Client is/is not cooperating with the treatment plan

Community resources available for this client include \_\_\_\_\_

Provider Signature: \_\_\_\_\_ Date: \_\_\_\_\_