

Recovery Phase			Clinician:
Date: - - d m yr		Present: <input type="checkbox"/> Client <input type="checkbox"/> Family: <input type="checkbox"/> Other:	Client:
			Location: <input type="checkbox"/> Office <input type="checkbox"/> Other:
<b>Client</b>	<b>Family</b>	<b>Topics</b> See education/psychosocial intervention section for overviews and handouts.  <input type="checkbox"/> Psychosis <input type="checkbox"/> Etiology <input type="checkbox"/> Early Intervention <input type="checkbox"/> Medication <input type="checkbox"/> Psychosocial Treatments <input type="checkbox"/> Stress Management <input type="checkbox"/> Relapse Prevention - develop prevention plan as early on as possible <input type="checkbox"/> Social Functioning <input type="checkbox"/> Lifestyle <input type="checkbox"/> Goal Setting <input type="checkbox"/> Problem Solving <input type="checkbox"/> Drugs and Alcohol <input type="checkbox"/> Persistent Symptoms <i>Other (please indicate):</i> <input type="checkbox"/> _____	<b>Progress Notes</b>
<input type="checkbox"/>	<input type="checkbox"/>	<b>Individualized Care and Reintegration</b> <ul style="list-style-type: none"> <li>● <i>Document:</i></li> <li><input type="checkbox"/> Progress made</li> <li><input type="checkbox"/> Obstacles encountered</li> <li><input type="checkbox"/> Revisions to individualized care or reintegration plans</li> </ul>	
<input type="checkbox"/>	<input type="checkbox"/>	<b>Ongoing Assessment</b> <ul style="list-style-type: none"> <li>● <i>At least every 3 months:</i></li> <li><input type="checkbox"/> Assessment update completed using Update Template</li> <li><input type="checkbox"/> 2-Com completed by client</li> <li><input type="checkbox"/> Assess family impact and well-being</li> <li><input type="checkbox"/> Review relapse prevention plan</li> </ul>	
<input type="checkbox"/>	<input type="checkbox"/>	<b>Other Care</b> <ul style="list-style-type: none"> <li>● <i>Maintain regular contact with:</i></li> <li><input type="checkbox"/> General physician</li> <li><input type="checkbox"/> Other care providers</li> <li>● <i>Provide based on need or readiness</i></li> <li><input type="checkbox"/> Referrals for other services</li> <li><input type="checkbox"/> Groups for client</li> <li><input type="checkbox"/> Groups for family</li> <li>● <i>If prolonged recovery is suspected</i></li> <li><input type="checkbox"/> Consult with psychiatrist</li> <li><input type="checkbox"/> Document plans to change course</li> </ul>	
<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