PSYCHIATRIC HOSPITAL
1234 Main Street
Anywhere, USA

Date of Exam: 6/29/2012
Time of Exam: 1:33:31 PM

Patient Name: Jennifer Smiley
Patient Number: 1000010645495

TREATMENT PLAN FOR JENNIFER SMILEY

Treatment Plan Meeting
A Treatment Plan meeting was held today, 6/29/2012, for Jennifer Smiley.

Diagnosis:

Axis I:	Major Depressive Disorder, Single, Severe w/o Psychotic Features, 296.23 (Active)
	Alcohol Dependence, 303.90 (Active)
Axis II:	Deferred Diagnosis 799.99
Axis III:	See Medical History
Axis IV:	Primary Support Group
	Occupational
	Grief: Death of daughter in 2011
Axis V:	50
	85 (Highest GAF in past 12 months)

Current Psychotropic:
#1) Prozac 30 mg. PO QAM
#2) Antabuse 250 mg. PO QAM
#3) Synthroid 100 mcg. PO QAM
#4) Ambien CR 6.25 mg PO at Hour of Sleep

Problems:
Problem #1: depressed mood

Problem = DEPRESSED MOOD

Jennifer's depressed mood has been identified as an active problem in need of treatment. It is primarily manifested by:
Thoughts of death or suicide - experienced almost daily.

Long Term Goal(s):
- Will score within normal Limits on the Beck Depression Scale.
- Will maintain compliance with psychotropic medications.

Target Date: 9/12/2012

Short Term Goal(s):
Jennifer will recognize and report thoughts of death to staff daily for one week.
She will attend daily grief support group.
She will attend 3 recreation activities per week.

Target Date: 5/1/2012

Intervention(s):
• Prescriber will examine patient and order consultations and lab as needed to arrive at all appropriate DIAGNOSES

• Prescriber to prescribe medications, monitor side effect, and adjust dosage to STABILIZE MOOD and minimize side effects.

• Prescriber will educate patient (patient's family) as to the RISKS AND BENEFITS of treatment and obtain informed consent, if appropriate.

• Therapist will provide emotional SUPPORT and encouragement, and help patient focus on sources of pleasure and meaning.

Status:

6/29/2012: The undersigned therapist met with the patient on the date above in a face to face meeting to work with him/her in developing this Treatment Plan.

Comprehensive Treatment Plan Barriers

Emotional problems interfere with treatment.
- Emotional problems will be dealt with via treatment plan.
- Jennifer is encouraged to keep a personal journal to assist in sorting out her thoughts and goals.

Comprehensive Treatment Plan Strengths
Jennifer's strengths include:

Cognitive
- Intellectually bright
- Can make needs known

Physical
- Is physically healthy

Upon completion of Long Term Goal, Discharge or Transition Plan includes:

Expected length of stay: 7 days

Continue with current therapist: Jason Jones, MD

Continue with current psychiatrist: Karen Johnston, MD

Other: _____

Signature below indicates that this Treatment Plan has been reviewed and approved:

Date: _____ Clinician: _____ Title: _____

Date: _____ Clinician: _____ Title: _____

Date: _____ Clinician: _____ Title: _____

Date: _____ Clinician: _____ Title: _____

Date: _____ Patient: _____

A copy of this treatment plan was: _____ given to the patient/family OR _____ declined by the patient/family.:

Date: _____ Clinician: _____ Title: _____

Electronically Signed
By: Elizabeth Lobao (MD)
On: 6/29/2012 1:35:59 PM

Note: Each member of the treatment team has the ability to e-sign this clinical record.