OUTPATIENT PSYCHIATRIC CLINIC
2121 Main Street
Raleigh, NC 27894
919-291-1343

Date of Exam: 3/13/2012
Time of Exam: 10:45 am

Patient Name: Smith, Anna
Patient Number: 1000010544165

TREATMENT PLAN FOR ANNA SMITH

Treatment Plan Meeting
A Treatment Plan meeting was held today, 3/13/2012, for Anna Smith.

Diagnosis:
Axis I: Generalized Anxiety Disorder, 300.02 (Active)
Axis II: None V71.09
Axis III: See Medical History
Axis IV: None
Axis V: 60

Current Psychotropics:
Paxil 10 mg PO QAM
Buspirone 10 mg PO QAM
Ambien CR 6.25 mg PO QHS
Synthroid 50 mcg PO QAM

Problems:
Problem #1: anxiety
_____
_____

Problem = ANXIETY

Anna's anxiety has been identified as an active problem in need of treatment. It is primarily manifested by:
Generalized Anxiety Disorder - with excessive worrying - with impairment in functioning.

Long Term Goal(s):
- will reduce overall level, frequency, and intensity of anxiety so that daily functioning is not impaired.
Target Date: 4/25/2012

Short Term Goal(s):
Anna will have anxiety symptoms less than 50% of the time for one month.
Target Date: 4/25/2012

In addition, Anna will exhibit increased self-confidence as reported by client on a self-report 0-10 scale weekly for two months.
Target Date: 5/13/2012

Intervention(s):
• Prescriber to monitor side effects and ADJUST MEDICATION DOSAGE to increase effectiveness and decrease SIDE EFFECTS, as appropriate for anxiety disorder once per week for one month.

Comprehensive Treatment Plan Barriers

Emotional problems interfere with treatment.
- Anna is fearful that her apprehensive symptoms will never be under good control.

Comprehensive Treatment Plan Strengths
Anna's strengths include:

cognitive
- Intellectually bright

communicative
- Has good communicative skills

family
- Good relationship with family

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

Continue with current therapist: Name _____

Continue with current psychiatrist: Name _____

Refer for follow up with: Name _____ Arranged by: _____

Refer for follow up with: Name _____ Arranged by: _____

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:_____ Clinician: _____ Title:_____

Date:_____ Patient: _____

Date:_____ Parent/Guardian: _____

Date:_____ Other: _____

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

Date:_____ Clinician: _____ Title:_____

Elizabeth Lobao, MD

Electronically Signed
By: Liz Lobao, MD
On: 3/13/2012 10:48:09 AM