Individualized Action Plan: Psychopharmacology

This form is designed to be used for persons who are receiving psychopharmacology services only (i.e. medication management and no therapy). If the person served is receiving other services in addition to medication management, the medication management goals should be included in the IAP. This form is to be completed by the primary provider of psychopharmacology services.

Note: For programs that are accredited by CARF or JCAHO be sure to include legal requirements as they relate to treatment including any restitution, e.g. court ordered treatment. For JCAHO include interaction with the criminal or juvenile justice system if applicable.

Data Field	Identifying Information Instructions (*Fields for Person's Name, Record Number, and D.O.B. must be completed on each page)
***Person's Name**	Record the first name, last name, and middle initial of the person being served. Order of name is at agency discretion.
***Record Number**	Record your agency's established identification number for the person.
Date of Admission	Record date of admission.
Organization Name	Record the organization for whom you are delivering the service.
***D.O.B**	Document date of birth of the person served.
Gender	Indicate person's gender by checking the appropriate box. If checking "Transgender" box, also complete box of current gender designation for insurance purposes.
Plan Completed by	Record the name of the person completing the Individualized Action Plan, his or her title, and the program(s) for which the plan is being developed.
Start Date	The date the person served and provider(s) will begin to work on this goal.
Target Completion Date	Record the date by which the person served would like to accomplish the goal or the date by which the person served and provider(s) believe the goal can be completed. This indicates the anticipated duration of treatment.
Adjusted Target Date	If the target date needs to be changed later, the new date is entered here.
Reason for Adjustment	If an adjustment is made to the target date, document the reason for the adjustment here.
Desired Outcomes in Person's Served Words	Document the goal in the words of the person served. This should reflect his or her desired outcome and can be used as a benchmark by the person and provider for determining success in achieving the goal as treatment progresses. ***Adult Outpatient Example:*** "I don't want to experience an episode like those two again… and if I do, I want to know how to respond." ***BSAS Example:*** I need to get off of Oxyies"
State Goal Below in Collaboration with the Person Served as Identified in the	Check off the source(s) (Psychiatric Evaluation and/or Comprehensive Assessment) of the identified need of the person served. Check the appropriate goal(s) in the list provided to indicate the desired outcomes of the person served (family/guardian as appropriate), or check *Other* and specify the goal.
Objectives	Check the appropriate objective(s) which will help person served reach his/her identified goal(s), or check *Other* and specify the objective.
Person's Strengths and Skills and How They Will be Used to Meet Goals	Document the strengths and skills that can be used to work towards accomplishing the person's goals. ***Adult Outpatient Example:*** Mary has skills in caring for others and being compassionate that she can use towards herself. Mary is willing to participate in treatment and wants to "get better." Generally, Mary states she does not like medicine, but she is willing to explore a conversation about her options. ***BSAS Example:*** Client is highly motivated to continue with MAT and has disclosed to his family his past struggle with Oxycodone and use of MAT for support.

Therapeutic Intervention Methods, Provider, Frequency, and Duration	Check the appropriate Therapeutic Intervention Methods and corresponding Provider(s), Frequency, and Duration of services for each intervention. If a therapeutic intervention is not listed, check *Other* and list. If a noted service has a frequency, which may fluctuate check *Other* in the Frequency section and write "See the Follow Up Plan on the Psychiatric Progress Note" or "Refer to _____ (insert name of other documentation source in record, which specifies frequency and rationale).
Referrals/Additional Evaluations	Check box(es) that best identifies additional assessment needs of the person served or check *Other* and list the additional assessment needed. Check none required as applicable.
Explained rationale, benefits, risks and treatment alternatives to/for the person served?	Check *Yes* or *No* if the rationale, benefits, risks and treatment alternatives contained in the Individualized Action Plan: Psychopharmacology were explained to the person served (parent/guardian as appropriate).
Data Field	**Transition/Level of Care Change/Discharge Plan**
Anticipated Date	Record the date of anticipated transition/discharge based on person's belief of when the criteria for such transition would be met and/or the provider's assessment.
How Will the Provider/Person Served/Parent/ Guardian Know That Level of Care Change is Warranted?	If "Other" document evidence, which supports or describes criteria. When discharge is indicated, provider should complete Transition Discharge Summary and Plan.
Data Field	**Referrals, Rationale, and Response Instruction**
Person Served/Guardian Response	Check appropriate response from person served (or parent/guardian as appropriate).
If Person Served refuses plan, describe plan for continuation of services	Document recommendations for follow up services if the person served has not agreed to the IAP: Psychopharmacology.
Person Served received a copy of the IAP?	Check *Yes* or *No* to indicate whether or not the person served received a copy of the IAP: Psychopharmacology. If *No*, provide explanation.

Data Field	Signatures Instruction
Person Signature (Optional if clinically appropriate)	The person served should be given the option to sign the IAP: Psychopharmacology. If the person does not sign, list the reason(s)/explanation, or document the reason(s)/explanation in a progress note (i.e. "See Progress Note dated 01/01/08).
Date	Document the date.
Parent/Guardian Signature (if appropriate)	The parent/guardian signature is necessary if person served is a minor or an adult who has a legal guardian. This space can also be used for any family/significant other as defined by the person served if he/she wishes them involved in process.
Date	Document the date.
Psychiatrist/MD/ DO – Print Name/Credentials	**Legibly** record **Psychiatrist/MD/DO**'s signature and credentials, according to agency policy, and date. Check if *Not applicable*.
Date	Document the date.
Psychiatrist/MD/DO Signature (If needed)	Record signature here.
Date	Document the date.
Next Appointment	Enter the date and time, indicating am or pm for the next scheduled appointment, if known.