

MASTER TREATMENT PLAN COVER SHEET

Axis I: _____ (to be completed by Attending Physician)

Participants in the development of this plan were:

<u>NAME (PRINT)</u>	<u>SIGNATURE</u>	<u>CREDENTIAL</u>	<u>DISCIPLINE</u>
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

I have reviewed the Multidisciplinary Problem Aggregate, Integrated Summary/Problem List, and Master Treatment Plan.

_____, Attending Physician

Date/Time: _____

PATIENT PARTICIPATION IN TREATMENT PLANNING (Check as Appropriate):

I acknowledge that I have been invited to participate in the planning of my treatment. _____ Patient's Signature and Date)

___ Agree with plan
___ Object to plan (specify below) _____ (Staff Signature/Date)

___ Refused to Participate
___ Unable to Participate
___ Refused to Sign Plan _____ (If Guardian, Relation to Patient)

___ Participating in Plan
_____ (Guardian's Signature and Date)

___ Phone contact w/guardian re. MTP (e.g. medication adjustments revisions in modalities, etc.) _____ (Staff Signature/Date)

Patient's Comments (Optional):

Staff's Comments (Optional):

MPA, INTEGRATED SUMMARY, AND MTP

MPA – Check (✓) triggers (positive findings) gathered from the discipline-specific (Nursing, Social Service staff) assessments. Complete within 24-72 hours of admission.

- | | | |
|--|--|--|
| <input type="checkbox"/> Agitation | <input type="checkbox"/> Homelessness | <input type="checkbox"/> Pain (specify)_____ |
| <input type="checkbox"/> Appetite disturbance | <input type="checkbox"/> Hopelessness/helplessness | <input type="checkbox"/> Paranoia |
| <input type="checkbox"/> Assaultive behavior/thoughts | <input type="checkbox"/> Hyper-religiosity | <input type="checkbox"/> Poor grooming/hygiene |
| <input type="checkbox"/> Confused | <input type="checkbox"/> Inappropriate elated mood | <input type="checkbox"/> Racing thoughts |
| <input type="checkbox"/> Delusional thoughts | <input type="checkbox"/> Irritability | <input type="checkbox"/> Sexual preoccupation |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Lack of concentration | <input type="checkbox"/> Sleep disturbance |
| <input type="checkbox"/> Disoriented | <input type="checkbox"/> Language barrier | <input type="checkbox"/> Social isolation |
| <input type="checkbox"/> Euphoria | <input type="checkbox"/> Legal problems | <input type="checkbox"/> Substance abuse |
| <input type="checkbox"/> Fall risk | <input type="checkbox"/> Lethargic | <input type="checkbox"/> Suicidal gestures |
| <input type="checkbox"/> Family conflict | <input type="checkbox"/> Nicotine Dependence | <input type="checkbox"/> Suicidal ideation |
| <input type="checkbox"/> Functional limitations (specify)_____ | <input type="checkbox"/> Non-compliant (specify)_____ | <input type="checkbox"/> Withdrawal, alcohol |
| | | <input type="checkbox"/> Withdrawal, benzodiazepines |
| <input type="checkbox"/> Grandiosity | <input type="checkbox"/> Obesity | <input type="checkbox"/> Withdrawal, cocaine |
| <input type="checkbox"/> Hallucinations (auditory/visual) | <input type="checkbox"/> Obsessive thoughts | <input type="checkbox"/> Withdrawal, opiates |
| <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Other Medical problems (specify)_____ | <input type="checkbox"/> Other (specify)_____ |

PATIENT ASSETS

- Education Employment Insight into problems Motivated for treatment Sense of humor
 Support system Support of faith group Other (specify)_____ Other (specify)_____

PATIENT STRESSORS

- Family conflict Health problem Poor coping skills Legal problems Recent loss Religious/spiritual conflicts
 Income deficit Unstable living situation Other (specify)_____ Other (specify)_____

INTEGRATED SUMMARY/PROBLEM LIST – Consolidation of clinical information by physician within 72 hours of admission. MTP is initiated after completion of this section by physician.

PRIORITIZATION CODES			* = HIGHEST PRIORITY N = NOTED AND WILL BE MONITORED AND/OR INVESTIGATED FURTHER X = NOTED BUT NO ACTION NECESSARY AT THIS TIME O = TO BE ADDRESSED THROUGH AFTERCARE (LONG TERM GOAL)				
PROB #	DATE	CODE	PSYCHIATRIC	PROB #	DATE	CODE	PHYSICAL
			<input type="checkbox"/> Psychosis				<input type="checkbox"/> Diabetes
			<input type="checkbox"/> Elevated Mood/Mania				<input type="checkbox"/> HTN
			<input type="checkbox"/> Depressed Mood				<input type="checkbox"/> Nicotine Dependence
			<input type="checkbox"/> Impulse Control				<input type="checkbox"/> Obesity
			<input type="checkbox"/> Aggression				<input type="checkbox"/> Withdrawal (specify)_____
			<input type="checkbox"/> Suicidal Thoughts/Behavior				<input type="checkbox"/> Seizure Disorder_____
			<input type="checkbox"/> Hyperactivity				<input type="checkbox"/> Other_____
			<input type="checkbox"/> Other_____				<input type="checkbox"/> Other_____
			<input type="checkbox"/> Other_____				<input type="checkbox"/> Other_____

ATTACH APPROPRIATE MTP SHEET TO THIS FORM.