



CSC

# COMMUNITY TREATMENT INTERVENTION PLAN

Date:

<b>Client's Name:</b>	<b>Date of Birth:</b>	<b>Age:</b>	<b>Gender:</b>	<b>Cqwt vUwr r qt vY qt ngt :</b>
<b>Place of Birth:</b>	<b>Person Lives:</b>		<b>Date of Admission:</b>	<b>Supports:</b>
<b>Physician:</b>	<b>Telephone:</b>		<b>Psychiatrist:</b>	<b>Telephone:</b>
<b>Crown:</b>			<b>Defense:</b>	
<b>Charge(s)</b>				

Summary of Presenting Concerns:



**Focus Area: Psychological Distress:**

**Summary:**

**Diagnosis: (confirmed or suspected)**

**PRESENTING SYMPTOMS/BEHAVIORS SUPPORTING CLIENT'S DIAGNOSIS & POSSIBLE IMPACT ON TREATMENT**

<input type="checkbox"/> Anxiety	<input type="checkbox"/> Paranoia	<input type="checkbox"/> Tearful	<input type="checkbox"/> Resistance	<input type="checkbox"/> Panic Attacks
<input type="checkbox"/> Relationship	<input type="checkbox"/> Oppositional	<input type="checkbox"/> IL skills	<input type="checkbox"/> Appetite	<input type="checkbox"/> Suicidal Ideation
<input type="checkbox"/> Addictions	<input type="checkbox"/> Aggression	<input type="checkbox"/> Sleep Disturbance	<input type="checkbox"/> Withdrawn	<input type="checkbox"/> Med. Non Compliance
<input type="checkbox"/> Avoidance	<input type="checkbox"/> Isolation	<input type="checkbox"/> Social Skills	<input type="checkbox"/> Impulsive	<input type="checkbox"/> Legal
<input type="checkbox"/> Labile Mood	<input type="checkbox"/> Distortion	<input type="checkbox"/> Hallucinations	<input type="checkbox"/> Depressed Affect	<input type="checkbox"/> Lack of Support
<input type="checkbox"/> OCD	<input type="checkbox"/> Pain Management	<input type="checkbox"/> Housing	<input type="checkbox"/> Poor Hygiene	<input type="checkbox"/> Stressors
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>



Hospital admissions: ( None or ( list names, dates of service, location):

Describe Conditions that may require Police or hospitalization:

Immediate Crisis Intervention Plan - In case of medical or psychiatric emergency, Client will be sent to the nearest hospital. Additionally, the following individuals shall be notified:

- Case Manager       Program Manager
- Family if required     Psychiatrist/Physician

Contact my family doctor or ER services if I am in a crisis?  Yes  No

Share this plan with PRHC Crisis Services?  Yes  No

Medication(s):

Intervention Strategy:

Focus Area: Substance Use

Intervention Strategy



<u>Focus Area Urine Screens</u>	<u>Intervention Strategy</u>
<u>Focus Area Accommodations</u>	<u>Intervention Strategy</u>
<u>Focus Area Abuse/Trauma</u>	<u>Intervention Strategy</u>
<u>Focus Area Legal</u>	<u>Intervention Strategy</u>



<u>Focus Area Safety to Self/Others</u>	<u>Intervention Strategy</u>
<u>Focus Area Natural Supports</u>	<u>Intervention Strategy</u>
<u>Focus Area ED/Voc</u>	<u>Intervention Strategy</u>
<u>Focus Area Physical Health</u>	<u>Intervention Strategy</u>



<u>Focus Area Financial</u>	<u>Intervention Strategy</u>
<u>Focus Area Activities of Daily Living</u>	<u>Intervention Strategy</u>
<u>Focus Area</u>	<u>Intervention Strategy</u>

I participated in the development of this plan and agree to this plan being presented to the MDT: \_\_\_\_\_

Case Manager's Signature: \_\_\_\_\_

Crown's Signature: \_\_\_\_\_