CONTRA COSTA
HEALTH SERVICES
BEHAVIORAL HEALTH DIVISION

NAME:_____

MRN: _____

DOB: _____

Partnership Plan For Wellness – Psychiatric Services

Consumer Strengths: _____

Consumer Goal: I (my child) will collaborate with my (child's) provider to **decrease/modify** the following **symptoms** related to my (child's) mental health diagnoses:

Current frequency/intensity of

the following specific symptom(s):

Target frequency/intensity of
specific symptom(s):

…So that I (my child) am better able to function in the following areas:

- ☐ activities of daily living/ self care
- ☐ employment / school performance
- ☐ food / shelter
- ☐ physical health
- ☐ family relationships
- ☐ recreation / leisure activities
- ☐ social relationships/ peer relations
- ☐ substance abuse

***Provider* strategies to achieve above goals** (specific/detailed description of provider interventions):

My role in achieving recovery (specific/detailed description of consumer's role):

Proposed duration of this plan is: ☐ **6 months** ☐ **one year**

My signature on this plan indicates my participation in discussion about its contents.

_____ _____

Consumer/Legal Responsible Party Signature* Date Psychiatrist/NP Signature Date

If signed by a representative, please indicate relationship _____

On_____, Consumer was offered and: ☐ **received** ☐ **declined** a copy of Treatment Plan.
Date

**Reason for not obtaining consumer signature:*_____

_____

Authorization Committee Signature Date

Additional Specific Goals, Objectives, and Strategies:

Psychiatrist or NP will update all identified goals in progress notes.

Consumer/Legal Responsible Party Signature* Date

Psychiatrist/NP Signature Date

**Reason for not obtaining consumer signature:*_____*