

ADHD Treatment Plan

PATIENT INFORMATION

First name: _____ Last name: _____

Date of birth: _____ dd / mm / yyyy

GOALS

Short-term goals:

Long-term goals:

INTERVENTIONS

Behavior therapy:

Pharmacological:

Other/Complementary treatment:

MANAGEMENT PLAN

Home:

School:

Other:

ADDITIONAL CLINICIAN NOTES

Specify below:

Vanderbilt templates provided: _____

Educational resources provided: _____

Follow-up date: _____ dd / mm / yyyy

Clinician name: _____

Clinician designation: _____

Clinician signature:

Date: _____ dd / mm / yyyy