Disruptive Mood Dysregulation Disorder (DMDD) Treatment Plan

Date of assessment: _____ dd / mm / yyyy

PATIENT INFORMATION

Name: _____ Date of birth: _____ dd / mm / yyyy

Gender: _____ Contact information: _____

Medical history (Specify below):

PRESENTING PROBLEMS

Symptoms observed:

Describe the mood dysregulation:

Duration of symptoms:

Previous interventions tried:

TREATMENT GOALS

Short-term:

Long-term:

INTERVENTIONS

I. Cognitive behavioral therapy (CBT)

Intervention specifics:

Implementation plan:

Timeline:

II. Medication management

Medication plan:

Dosages:

Monitoring requirements:

III. Parent training

Training sessions required:

Objectives:

Expected outcomes:

IV. School-based interventions

Coordination plan with school staff/teachers:

Intervention strategies:

COORDINATION OF CARE

Mental health professional involvement:

ADDITIONAL RESOURCES AND SUPPORT

Additional support:

Community resources:

Educational materials:

FOLLOW-UP PLAN

Check-in frequency:

Progress monitoring:

HEALTHCARE PROFESSIONAL INFORMATION

Name: _____ License ID number: _____

Signature:
Date: _____ dd / mm / yyyy