Paranoid Schizophrenia Treatment Plan

PATIENT INFORMATION

Patient Name: _____ Date of Birth: _____ dd / mm / yyyy

Gender

◯ Male ◯ Female ◯ Other

Treatment Start Date: _____ dd / mm / yyyy

PRESENTING PROBLEM/REASON FOR REFERRAL

Presenting Problem/Reason for Referral

DIAGNOSTIC IMPRESSIONS

Diagnostic Impressions

TREATMENT GOALS

Treatment Goals

TREATMENT INTERVENTIONS

Pharmacological Interventions

Pharmacological Interventions

Psychosocial Interventions

Psychosocial Interventions

Lifestyle Modifications

Lifestyle Modifications

SOCIAL SUPPORT RESOURCES

Social Support Resources

COLLABORATION AND COORDINATION

Primary Physician: _____ Psychiatrist: _____

Therapist: _____ Case Manager: _____

MONITORING AND FOLLOW-UP

Monitoring and Follow-up

DISCHARGE CRITERIA

Discharge Criteria

TREATMENT PLAN REVIEW AND REVISION

Treatment Plan Review and Revision

Patient Signature

Date: _____ dd / mm / yyyy

Provider Signature

Date: _____ dd / mm / yyyy