MASTER RECOVERY PLAN & REVIEW

(INDIVIDUAL SERVICE PLAN) Adult Mental Health Division

For Site Specific Use:

	Date of Birth:	
Last Name:	12-digit ECURA Reference # 2 0 _ _ _ _ _ _ _ _ _ _ _	Service Plan Date:
First Name:	Gender: ☐M ☐F ☐Other	Review Due:
Case Manager:		Review Done:
Qualified Mental Health Practitioner (QMHP):		2nd Review Due:

STRENGTHS/PREFERENCES/CULTURAL ISSUES	CONSUMER LONG TERM RECOVERY/DISCHARGE GOALS:

Case formulation can be found in ☐ Psychiatrist's Intake Report in record ☐ Attached ☐ Other:

DIAGNOSES	NEEDS IDENTIFIED BY CONSUMER:
Axis I: a	1.
b	2.
c	3.
d	4.
Axis II:	Criteria For Change in Level of Care:
Axis III:	
Axis IV:	
Axis V: (GAF) Current: Highest in Past Year:	GAF at review:
LOCUS: ☐CC ☐TCM ☐ICM ☐ACT ☐CSM	LOCUS at review: ☐CC ☐TCM ☐ICM ☐ACT ☐CSM

SPECIAL NEEDS CONSIDERATIONS FOR SERVICE PLANNING:

- ☐ Developmental Disability
- ☐ Chronic Homelessness
- ☐ Transportation
- ☐ Non-ambulatory
- ☐ Needs Interpreter
- ☐ Hearing Impaired
- ☐ Limited Sight
- ☐ No special needs
- ☐ Other:

Forensic Status: (*check one*)

☐ Voluntary ☐ Parole ☐ Conditional Release
☐ Probation ☐ Supervised Release ☐ Jail Diversion Participant

Probation/Parole Officer:
Phone:

☐ HCR 20 – Date completed:
Level of risk:

☐ MI/SA

Stage of Change: ☐Engagement ☐Motivation/Persuasion ☐Active/Action ☐Relapse Prevention

☐ Advance Directive:

CRISIS PLAN:

What are my triggers and warning signs?

Actions staff and I will take to *prevent* crisis: (Include names/numbers of my supporters/resources)

Actions	Person Responsible	Contact Information
1.		
2.		
3.		

Actions staff and I will take to *manage* crisis: (Include my preferred treatments/facilities *and* those I want to avoid)

Actions	Person Responsible	Contact Information
1.		
2.		
3.		

GOAL (Number to correspond with needs)	PLAN (Interventions including frequency, duration and person & discipline responsible. Include referrals here.)	STATUS (See key at bottom of page)

Explanation for identified consumer needs/goals that are not addressed in the ISP:

Consumer:	Date:	Psychologist/ APRN:	Date:
Psychiatrist:	Date:	Legal Guardian:	Date:
Case Manager:	Date:	Other:	Date:

Status Key:
OM = Outcome Met   If outcome not met, choose one:
W = Worse   NC = No Change   I = Improvement   DC = Discontinued