Partnership Plan for Wellness: Adult Services (Practitioners and RNs)

This plan is to describe my treatment goals and responsibilities.
My psychiatrist and I will work on this plan together and review these goals at least every 6 – 12 months.

My Strengths:

_____

_____

I will collaborate with my Practitioner to minimize or eliminate my symptoms and to prevent or minimize medication side effects so that I may better live a life of my own choosing.

Specify goals for my treatment may include (√ *all appropriate boxes)*:

- ☐ To feel well
- ☐ To find meaningful and satisfying work
- ☐ To become more self-reliant and/or live independently
- ☐ To enjoy a better social life
- ☐ To go to school or get training
- ☐ To avoid the need for hospitalization
- ☐ To better understand the potential benefits, risks and side effects of my medication.
- ☐ To understand my treatment options including other medications and alternatives to medication.
- ☐ Easily identify steps to improve my health at each visit so my treatment is safe, specific and effective.
- ☐ I will be able to recognize side effects of my medications or other concerns I might have regarding my treatment.
- ☐ Achieve and maintain sobriety
- ☐ Take my medication as prescribed.
- ☐ Attend appointments with my psychiatrist regularly.
- ☐ I will discuss with my psychiatrist whenever I engage in self-harmful activities.

Additional goals for my treatment:

_____

_____

_____

_____

_____

(Continued on page 2)

Strategies to achieve goals:

- ☐ I will understand and be able to describe at each visit, the potential benefits, risks, and side effects of my medications, or other concerns I have regarding treatment.
- ☐ I will understand my treatment options, including other medications and alternatives to medications and discuss them with my psychiatrist at each visit.
- ☐ I will identify and discuss different steps to improve my health at each visit so that my treatment is safe, specific, and effective.
- ☐ I will take my medication as prescribed and report to my psychiatrist at each visit the difficulty I have doing so.
- ☐ I will attend all of my appointments with my psychiatrist.
- ☐ I will attend monthly medication support group (if available).
- ☐ I will discuss with my psychiatrist whenever I engage in self-harmful activities and discuss strategies to prevent such activities.
- ☐ I will identify stressors or events that trigger a crisis and discuss with my psychiatrist at each visit, stressors as they come up.
- ☐ I will discuss with my psychiatrist, any and all behavioral health conditions, challenges and my recovery process.
- ☐ I will participate in the recovery process to achieve and maintain clean and sober living.

I can help my own treatment by learning about self-care recovery strategies and developing a trusting relationship with my practitioner. It is important for me to feel comfortable talking with my doctor about changes in symptoms, concerns about my medications, and any side effects that I experience.

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

_____ _____

Consumer and/or Representative's Signature* Date Practitioner/RN Signature Date

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

Date

**If no signature, see progress note dated:* _____

Goals for my treatment added or changed after signature above: (Please date additions or changes.)

_____

_____

_____

My signature indicates my participation in discussion about these additions or changes to this plan.

_____ _____

Consumer/Representative's Signature* Date Practitioner/RN Signature Date

On_____, Consumer was offered and: ☐ **received** ☐ **declined** a copy of amended Partnership Plan. **If no signature, see progress note dated:* _____

_____

Auth. Committee Signature Date