NorthSTAR Outpatient Treatment Plan

Name: _____ **NorthSTAR ID:** _____

Provider Name: _____ **Provider Number:** _____

Date of Treatment Plan: _____/_____/_____ **Authorization Start Date:** ____/____/_____
(if different than date of treatment plan)

Program Type: _____**Child** _____**Adult**

Axis 1:_____
Axis 2:_____
Axis 3:_____
Axis 4:_____
Axis 5: _____

Current medications:

Medication Name	Dosage	Frequency	Remarks

Symptoms/stressors that are a current focus of treatment including mental health, substance abuse, and medical:
(Include specific examples of diagnostic criteria, difficulties in functioning, stressors that lead to difficulty in functioning, history and current substance abuse, history and current medical conditions.)

Treatment history including recent hospitalizations, SPN services, history of therapy/counseling and results, length of current therapy/counseling episode, etc.: _____

Strengths: (*Identify positive attributes and strength-based strategies that will be utilized in recovery)*

Barriers to Treatment: (*Identify obstacles that interfere with recovery)*

Estimated discharge/step-down plan and planned interventions *(what is needed for member to "graduate" from therapy)*

_____
_____
_____
_____
_____

Identify goals of treatment and progress towards goals:

1. _____
_____
_____
Estimated time needed for achieving objective: _____Intervention:_____
Was this objective a goal on the prior treatment plan: YES / NO (If Yes Describe need for continued objective)
_____
_____

2. _____
_____
_____
Estimated time needed for achieving objective: _____Intervention:_____
Was this objective a goal on the prior treatment plan: YES / NO (If Yes Describe need for continued objective)
_____
_____

3. _____
_____
_____
Estimated time needed for achieving objective: _____Intervention:_____
Was this objective a goal on the prior treatment plan: YES / NO (If Yes Describe need for continued objective)
_____
_____

4. _____
_____
_____
Estimated time needed for achieving objective: _____Intervention:_____
Was this objective a goal on the prior treatment plan: YES / NO (If Yes Describe need for continued objective)
_____
_____

5. _____
_____
_____
Estimated time needed for achieving objective: _____Intervention:_____
Was this objective a goal on the prior treatment plan: YES / NO (If Yes Describe need for continued objective)
_____
_____

_____ _____ Date: _____/_____/_____
Provider Signature *Credentials*

_____ Date: _____/_____/___
Member Signature (Guardian if member is a minor)