State of Illinois
Department of Human Services - Treatment & Detention Facility

Master Treatment Plan Review

Name: _____ DHS Number: _____ Date of Review: _____

Date of Admission: _____ Status: _____ Primary Therapist: _____

TREATMENT PHASE:

Notes:

DIAGNOSIS:

AXIS I:

AXIS II:

AXIS III:

AXIS IV (DESCRIBE AND CIRCLE SCORE):

0	1	2	3	4	5	6
Inadequate Information	None	Mild	Moderate	Severe	Extreme	Catastrophic

AXIS V: ASSESSMENT OF FUNCTIONING:

Current GAF: _____ Highest Past Year: _____

Master Treatment Plan Review

NAME:
DHS Number:
Date:
TREATMENT PHASE:
Treatment Commitment:
Therapeutic Alliance:
Peer Interaction:
Cooperating with Staff and Rules:
Treatment Group Interaction:
Psychotropic Medication Compliance:

Master Treatment Plan Review

NAME:

DHS Number:

Date:

TREATMENT PHASE:

RESIDENT PARTICIPATION IN TREATMENT PLANNING (STAFF/RESIDENT INITIAL AS APPROPRIATE):

Contributed to Goals and Plans	_____	Refused to Participate	_____
Aware of Plan Content	_____	Unable to Participate	_____
Agrees with Plan Content	_____	Refused to Sign Plan	_____
Present at Team Meeting	_____		

Resident's Goals and Comments (Resident is encouraged to list 3 personal goals for the upcoming quarter):

Staff's Comments (Notes/Treatment Progress Summary):

Master Treatment Plan Review

NAME:
DHS Number:
Date:
TREATMENT PHASE:

TREATMENT TEAM MEMBERS:		
Signatures	Title	Date

Signature indicates that I have been informed of the specific recommended course of treatment in this plan, have discussed it, and had my questions answered, I understand what has been recommended, and give my consent to be so treated.

SIGNATURE - RESIDENT: _____ DATE: _____

Resident Refused to Sign Care Plan -Primary Therapist Signature: _____ DATE: _____

Signature - Staff Witness to Informed Consent/
Resident Refusal to Informed Consent: _____ DATE: _____