San Bernardino County
Department of Behavioral Health

MEDICATION SUPPORT SERVICES CLIENT PLAN

"A partnership in wellness"

Diagnostic Symptoms and related impairments

Diagnostic (Dx) Symptoms:

Observable, measurable, functional impairments related to diagnostic symptoms:

Client Driven Goals *(Behavioral, Measurable Objectives with time frames and quantifiable measures)*

To be achieved by _____ *(plan end date or goal target date)*

1. Client will reduce/increase _____ from _____ times per_____
   (circle one) *(observable, measurable behavior)* *(frequency)* *(hr.,day,wk.,mo.)*
   to a goal of _____ times per _____/_____ as measured by _____
   (frequency) *(hr,day,wk,mo)* *(sustained for)* *(self-report, observation, etc.)*
2. Client will reduce/increase _____ from _____ times per _____
   (circle one) *(observable, measurable behavior)* *(frequency)* *(hr.,day,wk.,mo.)*
   to a goal of _____ times per _____/_____ as measured by _____
   (frequency) *(hr,day,wk,mo)* *(sustained for)* *(self-report, observation, etc.)*

(Also see MSS ID notes and order sheet as part of the Plan for MSS)

Strengths:

☐ **Family Support** ☐ **Participates actively in treatment** ☐ **Clean and sober**
☐ **Awareness of psychiatric condition** ☐ **Compliant with treatment and follow up appointments**
☐ **Other (Describe):** _____

Interventions:

☐ **Provide medication evaluation/prescriptions/monitoring as indicated:**_____
(appointment frequency)

☐ **Provide supervision for case management services** ☐ **Coordinate with support system**
☐ **Educate patient on medication and side effects** ☐ **Psychosocial education**
☐ **Educate patient to appropriately utilize community resources** ☐ **Other:**_____

☐ **Encourage participation in other treatment services:**

☐ **Mental Health Counseling** ☐ **Alcohol and Drug Counseling** ☐ **Treatment for Medical Condition**

Plan Start Date:_____**Plan End Date:**_____ *(for clients receiving multiple services, this date is not to extend beyond the end date of the general Client Plan)*

Client* **Date** **Parent/Guardian *(if applicable)*** **Date**

***If no signature, or late dated signature, see progress note dated:** _____ (date)

☐ **Copy of Plan was given/sent to client** _____ *(date)*
☐ **Copy of Plan offered, but was declined by client**

Staff Signature **Date** **Staff Printed Name and Title**

Physician's Signature **Date** **Printed Name**

Medication Support Services Plan
County of San Bernardino
Department of Behavioral Health
Confidential Patient Information
See W & I Code 5328
Revised 05/09 BLUE

NAME:
CHART NO:
DOB:
PROGRAM: