TREATMENT PLAN TEMPLATE | PSYCHIATRY

Patient Name:	Start Date:

Dx/Presenting Problem:	
Primary: *(DSM-5 Criteria Met Yes/No)*	*Secondary (if applicable):*
Differential Considerations:	*Comorbidities:*
Assessment Tools Used: • *PHQ-9/GAD-7/YMRS/PANSS/MMSE (circle one)* • *Baseline score: ____* • *Target improvement goal: ____*	

Medication Management:				
Current Medications				
Name:	*DOS:*	*Start Date*	*RSP* ❒ Good ❒ Poor ❒ Side Effects	*Next Adjustment:*
Name:	*DOS:*	*Start Date*	*RSP* ❒ Good ❒ Poor ❒ Side Effects	*Next Adjustment:*
Medication Trials				
Past Trials (if applicable)			*Reason for discontinuation:*	

<table>
<tr><td colspan="2">Goals and Objectives: Define measurable goals and actionable steps for patient progress.</td></tr>
<tr><td colspan="2">Long Term Goal 1:</td></tr>
<tr><td rowspan="2">Objective 1:</td><td>Intervention(s)</td></tr>
<tr><td>Duration/Frequency:</td></tr>
<tr><td rowspan="2">Objective 2:</td><td>Intervention(s)</td></tr>
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<tr><td rowspan="2">Objective 3:</td><td>Intervention(s)</td></tr>
<tr><td>Duration/Frequency:</td></tr>
<tr><td colspan="2">Long Term Goal 2:</td></tr>
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Goals and Objectives: *Define measurable goals and actionable steps for patient progress.*	
Objective 2:	*Intervention(s)*
	Duration/Frequency:
Objective 3:	*Intervention(s):*
	Duration/Frequency

Medical Necessity Checklist
1. Diagnosis & Symptoms

Medical Necessity Checklist

❒ *DSM-5 diagnostic criteria met for_____*
❒ *Rating scale(s) used for baseline & follow-up*
❒ *Medication trial documented (if applicable)*
❒ *Side effects & adherence assessed*
❒ *Risk-benefit assessment for ongoing treatment*

2. Clinical Justification

❒ *Treatment/procedure aligns with **evidence-based guidelines***
❒ *Condition **would likely worsen** without this intervention*
❒ *Non-invasive or lower-cost alternatives **were attempted or ruled out***
❒ *Treatment is not primarily for patient preference, convenience, or cosmetic purposes*

3. Previous Treatments & Alternatives Considered

❒ ***Conservative treatments attempted:***

❒ *Medication trials*
❒ *Lifestyle modifications*
❒ *Therapy/counseling*
❒ *Support groups/social support*
❒ *Other (specify): _____*
❒ *Documented reason for **why alternatives were ineffective or inappropriate***

4. Provider's Clinical Judgment & Supporting Evidence

❒ *Medical notes document **necessity of intervention***
❒ *Risk-benefit assessment performed and documented*
❒ *Expected clinical outcome with treatment: _____*

5. Insurance/Payer Criteria Compliance

❒ *Meets payer-specific **medical necessity guidelines***
❒ *Required **pre-authorization obtained** (if applicable)*

Medical Necessity Checklist
❒ *Documentation includes:* • ❒ *Physician's rationale* • ❒ *Supporting test results* • ❒ *Prior authorization reference number (if applicable)*

Provider Attestation		
I attest that the above treatment plan is medically necessary and aligns with clinical guidelines.		
Provider Name:	**Signature:**	**Date:**

Progress Plan: *Milestone dates for assessment, with a transition plan or alternative actions if needed.*
Date to Reassess Symptoms: *Every [ ] weeks*
Symptom Rating Scale Change: *PHQ-9/GAD-7/YMRS score: ____ → ____*
Medication Adjustments: • *Maintain / Increase / Decrease / Discontinue _____* • *Side effects noted: Yes / No* • *Next step: _____* • *Maintain / Increase / Decrease / Discontinue _____* • *Side effects noted: Yes / No* • *Next step: _____*