Mental Health Treatment Plan (MHTP)

CONFIDENTIAL

Date: _____ Patient: _____ Service type: _____ Start Date: _____ Duration: _____

Area of need:

Present level:

Measurable Long-term Goal (SMART):

Who need to be informed about the progress?

#1 Name _____ period: W/M/Q/Y

#2 Name _____ period: W/M/Q/Y

Period review dates

1. _____
2. _____
3. _____
4. _____

Progress towards goal(s)

1. _____
2. _____
3. _____
4. _____

Sufficient progress to meet goal?

Yes / No: _____

Yes / No: _____

Yes / No: _____

Yes / No: _____

Short term objective #1

Date: _____

Achieved: Y / N

Person(s) responsible: _____

Short term objective #2

Date: _____

Achieved: Y / N

Person(s) responsible: _____

Area of need:

Present level:

Measurable Long-term Goal (SMART):

Who need to be informed about the progress?

#1 Name _____ period: W/M/Q/Y

#2 Name _____ period: W/M/Q/Y

Period review dates

1. _____
2. _____
3. _____
4. _____

Progress towards goal(s)

1. _____
2. _____
3. _____
4. _____

Sufficient progress to meet goal?

Yes / No: _____

Yes / No: _____

Yes / No: _____

Yes / No: _____

Short term objective #1

Date: _____

Achieved: Y / N

Person(s) responsible: _____

Short term objective #2

Date: _____

Achieved: Y / N

Person(s) responsible: _____

Patients Signature Date

Signature of Mental Health Services Representative Date