



110000

PLACE LABEL HERE.
IF LABEL NOT AVAILABLE, WRITE IN PT NAME & MR#

**PSYCHIATRIC SERVICES INTERDISCIPLINARY TREATMENT PLAN
PATIENT PARTICIPATION**

I have participated in the development of this plan and I agree with the treatment plan.

I have exceptions or objections to the plan. Details below:

Patient Name/Signature _____ Date _____

If applicable:

Authorized Representative Name/Relationship _____ Date _____

I reviewed and approve the treatment plan.

Psychiatrist Name/Signature/PIC _____ Date/Time _____

Patient/Authorized Representative was unable to sign.

Patient/Authorized Representative verbally agreed to plan but declined or was unable to sign.

Patient/Authorized Representative refused to sign.

Interpreter used _____

CARE PROVIDER

PRINT NAME _____ SIGNATURE _____ TITLE _____ DATE/TIME _____