Partners in Recovery

BEHAVIORAL HEALTH SERVICE PLAN REVIEW OF PROGRESS

Name:

I. Review of Progress for Hospitalized Person

Provide a summary below of the progress the person has made toward meeting the objectives identified on the service plan. In addition, indicate any adjustments that are being made to the service plan objectives and/or measures, including the justification and any additional needs or strengths that have been identified.

A. **Why is this person being hospitalized now? In other words, what were the circumstances, precipitants or stressors that contributed to hospitalization at this time?**

B. **Was the Individual Service Plan (ISP) fully implemented prior to this hospitalization? If not, how did this contribute to the hospitalization?**

C. **What needs to change (behaviors, thoughts, circumstances) in order for the person to be discharged from the hospital? In other words, what is the primary goal of this hospitalization?**

D. **List the treatment interventions that need to occur in the hospital in order to prepare the person for discharge.**

   1.

   2.

   3.

   4.

E. **What services need to be in place before the person can be discharged?**

   1.

   2.

   3.

   4.

F. **Does the person and his/her identified supports agree with the treatment interventions and services proposed? If not, why?**

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G. Does the person have an adequate living situation upon discharge? If not, what is the plan to secure stable housing? Does the person and his/her identified supports agree with the proposed placement? If not, why?

H. If this person needs a sub-acute, residential or other provider supervised setting, then please answer the following questions (CRU, 24 hr & Co-Occurring Residential, PAH/SIL, etc.):

1. **What skills must this person learn and/or what additional treatment needs to occur in this setting?**

2. **If this person requires supervision over night, e.g. 24 hour Residential, please describe the behaviors or concerns that necessitate this level of supervision.**

3. **How will the clinical team monitor progress and what will be the frequency?**

4. **Does the person and his/her supports agree with this placement?**

5. **Where will this person <u>live</u> after acquiring the necessary skills and/or completing the treatment?**

I. Are there any other barriers to discharging the person back into the community once they are discharge ready? If yes, what is the specific plan to address each barrier?

1.

2.

3.

J. Is this "Review of Progress for Hospitalized Persons" (ROP) prepared by the outpatient clinical team consistent with the "Inpatient Treatment and Discharge Plan" (ITDP) prepared by the inpatient clinical team? If not, please explain below:

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K. What modifications need to be made to the ISP to reflect both this ROP and the ITDP? Does the person and his/her supports agree with the modifications? If not, why? If necessary, what is the alternative plan?

II. Current Diagnostic Summary

Describe and explain any changes in diagnoses and functioning of person:

III. Date of Next Plan Review (CFT Planning) Meeting: _________________

V. Clinical Liaison (responsible for reviewing clinical record)

______________________________________		____________
Consumer Signature		Date
Guardian's Name (print) / Signature		Date
Clinical Liaison's Name (print) / Signature	Credentials/Position	Date
Doctor's Name (print) / Signature	Credentials/Position	Date
Nurse's Name (print) / Signature	Credentials/Position	Date
Rehab/Voc Specialist's Name (print) / Signature	Credentials/Position	Date
Case Manager's Name (print) / Signature	Credentials/Position	Date
Case Manager's Name (print) / Signature	Credentials/Position	Date

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Other (print) / Signature	Credentials/Position	Date
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