

**INSTRUCTIONS FOR  
OUTPATIENT TREATMENT PLAN**

- This form is only to be used by an outpatient treatment agency that intends to treat the patient on an outpatient basis.
- This form is required before the hearing for court ordered treatment, whenever there is a change in outpatient provider, or when there is a significant change in the outpatient treatment plan.
- If this form is not received prior to hearing, the Court will issue an in-patient only order. The court-ordered treatment will expire upon release of the patient from in-patient treatment.
- Fill out this form completely.** Information related to the MH case number can be obtained through the Mental Health Court Liaison at 520-483-5893 or, if the patient is already on Court Ordered Treatment, it will be found on the signed Court Order for Treatment.
- The CIS or ID Number is internal to the outpatient treatment agency and for their use only.
- The address in section 4a is required by statute.** If this section of the form is not accurate or missing, the form is not valid and will be rejected.
- This form must be signed by the Medical Director of the Outpatient Treatment Agency.** If it is not signed by the Medical Director, the form is not valid and will be rejected.
- Please fax this document to the Pinal County Attorney's Office – Civil Division, Attn: Mental Health Attorney, 520-866-6521. The original should be sent to their mailing address at PO Box 887 Florence AZ, 85132.

Please contact the Pinal County Attorney's Office and request the Mental Health Attorney at 520-866-6271 or call the Mental Health Court Liaison at 520-483-5893 if you have any further questions about filling out this document.

# OUTPATIENT TREATMENT PLAN

Patient Name: \_\_\_\_\_ D.O.B: \_\_\_\_\_ MH#: \_\_\_\_\_

CIS or ID # \_\_\_\_\_ Outpatient Treatment Provider: \_\_\_\_\_

Provider Phone #: \_\_\_\_\_ Provider Fax: \_\_\_\_\_

Case Manager Name: \_\_\_\_\_ - \_\_\_\_\_ and: Contact for D/C Planning: \_\_\_\_\_ - \_\_\_\_\_

1. The following treatment plan may be initiated at such time as (check applicable choices):

- A. The patient no longer requires continued inpatient treatment
- B. The patient will be more appropriately treated in an outpatient setting
- C. The patient will follow a prescribed outpatient treatment plan.
- D. The patient will likely not be a danger to others, a danger to self, or become gravely disabled if the patient follows the treatment plan.

2. Outpatient Treatment Requirements (check applicable choices):

- A. The patient will adhere to utilization of medication(s) of type and dosage as designated by a treating physician.
- B. The patient will keep treatment appointments as designated by the psychiatrist.
- C. The patient will maintain food and shelter appropriate to level of care as designated by psychiatrist and/or will accept the referral to obtain same by designated case manager and arrangements must be approved by treating physician.
- D. Should such referral/placement be made, the patient will adhere to the regulations pertaining to patient care as specified by such agency/designated supervisor/facility.

3. At present, the recommended placement with respect to level of care and supervision is (check applicable choices):

- 1.  Independent Living (home)    2.  Nursing Home    3.  Half way House
- 4.  Alcohol Rehabilitation    5.  Residential Treatment    6.  Transitional Living Shelter
- 7.  Other: \_\_\_\_\_

A. The outpatient treatment provider will coordinate with the inpatient facility to arrange transportation for the patient.

4. Residence/placement:

A. The patient will reside at: \_\_\_\_\_ City: \_\_\_\_\_ State: AZ Zip Code: \_\_\_\_\_

B. Residence Contact Name: \_\_\_\_\_ Residence Phone #: \_\_\_\_\_

5. The following named person, agency or organization is assigned and will have full extent of authority or organization in the implementation and provision of continued supervision and treatment and accepts responsibility for same.

\_\_\_\_\_

6. Conditions for Continued Outpatient Treatment: The patient will adhere to the following as designated/prescribed by the treating psychiatrist:

- A. Continuation of all medications.
- B. Submission to all tests/examinations
- C. Restriction of travel.
- D. Restriction of Alcohol.
- E. Restriction of substances/drugs.
- F. Restriction of incurrence of debts and obligations.
- G. Periodic reporting.
- H. Maintenance of shelter appropriate to level of care needs.
- I. Coordinate with case manager/social worker to obtain shelter and accept recommended referral.
- J. Forced administration of involuntary medications as needed.

Comments: \_\_\_\_\_

Medical Director Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Printed Name of Medical Director: \_\_\_\_\_