MSDP

Individualized Action Plan: Detoxification
Revision Date: *3-7-09*

Person's Name (First / MI / Last):	**Record#:**	**D.O.B.:**
Organization Name:		

Date of Admission:	**Anticipated Discharge Date:**	**Date Plan Initiated:**	**Plan Completed by (Name, Title, Program):**
Linked to Assessed Need(s) #: ☐CA ☐CA Update ☐ Psych Eval. ☐ Other:		**from form dated:**	

Desired Outcomes in Person's Words:

Treatment Area: Acute Withdrawal ☐Active ☐Referred ☐Monitoring ☐Not Clinically Indicated		**Goal Target Date:**	Adjusted Target Date:
Goal:	☐ Medical detox component will be completed with minimal physiological and psychological complications. ☐ Other:		
Objectives:	☐Person will complete medication protocol per physician orders. ☐Withdrawal symptoms will be monitored and treated. ☐If person is pregnant, the pregnancy protocol will be followed. ☐Other:		
Therapeutic Intervention(s)/ Method(s)		**Frequency**	**Responsible: (Type of Provider)**
☐ Person will receive medication as prescribed by the M.D.		☐See Physician's Orders ☐Other:	☐M.D. ☐Nurse ☐Counselor ☐Other:
☐ Vital signs will be monitored per physician's orders.		☐See Physician's Orders ☐Other:	☐M.D. ☐Nurse ☐Counselor ☐Other:
☐Other:		☐See Physician's Orders ☐Other:	☐M.D. ☐Nurse ☐Counselor ☐Other:

Treatment Area: Medical Issues ☐Active ☐Referred ☐Monitoring ☐Not Clinically Indicated		**Goal Target Date:**	Adjusted Target Date:
Goal:	☐ Medical issues will not interfere with the completion of the detoxification program. ☐ Other:		
Objectives:	☐ Person's medical issues will be assessed and monitored ☐ Person will follow physician's orders regarding the treatment of medical issues. ☐ Person will be educated on the medical issue and proper care. ☐Other:		
Therapeutic Intervention(s)/ Method(s)		**Frequency**	**Responsible: (Type of Provider)**
☐ A physical exam will be conducted within 24 hours of admission.		☐See Physician's Orders ☐Other:	☐M.D. ☐Nurse ☐Counselor ☐Other:
☐ All identified medical issues will be noted in the record and monitored by the program.		☐See Physician's Orders ☐Other:	☐M.D. ☐Nurse ☐Counselor ☐Other:
☐Prescription medications and treatments prescribed by a physician to manage the medical issue will be provided to person.		☐See Physician's Orders ☐Other:	☐M.D. ☐Nurse ☐Counselor ☐Other:
☐Other:		☐See Physician's Orders ☐Other:	☐M.D. ☐Nurse ☐Counselor ☐Other:

Treatment Area: Emotional/Behavioral/Psychiatric ☐Active ☐Referred ☐Monitoring ☐Not Clinically Indicated		**Goal Target Date:**	Adjusted Target Date:
Goal:	☐ Emotional/Behavioral/Psychiatric issues will not interfere with completion of the detoxification program. ☐ Other:		
Objectives:	☐The person's emotional, behavioral, and/or psychiatric issues will be assessed and monitored. ☐Other:		
Therapeutic Intervention(s)/ Method(s)		**Frequency**	**Responsible: (Type of Provider)**
☐ Person will meet with counselor to review any emotional, behavioral, and/or psychiatric issues that need to be monitored during treatment.			☐M.D. ☐Nurse ☐Counselor ☐Other:
☐Other:			☐M.D. ☐Nurse ☐Counselor ☐Other:
☐Other:			☐M.D. ☐Nurse ☐Counselor ☐Other:

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Treatment Area: Acceptance ☐Active ☐Referred ☐Monitoring ☐Not Clinically Indicated	**Goal Target Date:**	Adjusted Target Date:
Goal:	☐ Substance use will be accepted as a problem and participation in recovery program & services will be active. ☐ Other:	
Objectives:	☐ Person will complete a continuing recovery care plan by the third session. ☐ Person will identify 3 personal consequences that result from substance use disorder and 3 positive results of recovery. ☐Other:	

Therapeutic Intervention(s)/ Method(s)	**Frequency**	**Responsible: (Type of Provider)**
☐ Person will attend groups focusing on the importance of accepting substance use as a problem.		☐M.D. ☐Nurse ☐Counselor ☐Other:
☐ Person will meet with counselor to review level of acceptance of treatment.		☐M.D. ☐Nurse ☐Counselor ☐Other:
☐Other:		☐M.D. ☐Nurse ☐Counselor ☐Other:

Treatment Area: Recurrence Potential ☐Active ☐Referred ☐Monitoring ☐Not Clinically Indicated	**Goal Target Date:**	Adjusted Target Date:
Goal:	☐ Recurrence prevention techniques will be used to prevent potential recurrence of substance use. ☐ Other:	
Objectives:	☐ Person will identify 2 personal urges, 2 cravings, and 2 high risk situations that could lead to recurrence. ☐ Person will learn recurrence prevention process through identifying 2 coping strategies. ☐Other:	

Therapeutic Intervention(s)/ Method(s)	**Frequency**	**Responsible: (Type of Provider)**
☐ Person will attend recurrence/relapse prevention group.		☐M.D. ☐Nurse ☐Counselor ☐Other:
☐ Person will review recurrence prevention techniques with clinical staff and complete a recurrence prevention plan.		☐M.D. ☐Nurse ☐Counselor ☐Other:
☐Other:		☐M.D. ☐Nurse ☐Counselor ☐Other:

Treatment Area: Recovery Environment ☐Active ☐Referred ☐Monitoring ☐Not Clinically Indicated	**Goal Target Date:**	Adjusted Target Date:
Goal:	☐ Environment will be supportive of recovery. ☐ Other:	
Objectives:	☐Person will complete a continuing recovery care plan by the third session. ☐Person will identify 3 opportunities to improve his or her recovery environment. ☐Person will identify 3 community resources available that provide a recovery environment that is conducive to abstinence. ☐Person will identify continuing care recovery plan components and strategies he or she believes will help in recovery. ☐Other:	

Therapeutic Intervention(s)/ Method(s)	**Frequency**	**Responsible: (Type of Provider)**
☐ Person will attend groups focusing on importance of stability and support in recovery environment and will review his or her own environment for changes that can be made.		☐M.D. ☐Nurse ☐Counselor ☐Other:
☐ The program will assess the person's need for continuing care recovery planning services.		☐M.D. ☐Nurse ☐Counselor ☐Other:
☐ Person will meet with his or her clinician/counselor to develop the continuing care recovery plan.		☐M.D. ☐Nurse ☐Counselor ☐Other:
☐Other:		☐M.D. ☐Nurse ☐Counselor ☐Other:

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Treatment Area: Other: ☐Active ☐Referred ☐Monitoring ☐None Indicated		**Goal Target Date:**	Adjusted Target Date:
Goal:	☐ Other:		
Objectives:	☐ Other:		
Therapeutic Intervention(s)/ Method(s)		**Frequency**	**Responsible: (Type of Provider)**
☐			☐M.D. ☐Nurse ☐Counselor ☐Other:
☐			☐M.D. ☐Nurse ☐Counselor ☐Other:
☐			☐M.D. ☐Nurse ☐Counselor ☐Other:

Person Understands Stated Goals and Objectives? ☐ Yes ☐ No **/ Person Agrees?** ☐ Yes ☐ No / **Person's Initials:**

Person's strengths and skills and how they will be used to meet goals:

Supports and Resources needed to meet goals (include anticipated collateral and consultation contacts):

Potential Barriers to meeting these goals:

Legal Requirements – *describe any legal requirements, ordered restitution, court ordered treatment:* ☐ N/A

Discharge Plan/ Aftercare Plan:

Transition/Level of Care Change/Discharge Plan	**Anticipated Date:**

Criteria - *How will the provider/person served/parent/guardian know that level of care change is warranted?*
(Check All that Apply):

☐ Per physician's order, the person completed medical detoxification from the substance(s) from which he or she was withdrawing upon entering the program.

☐ Person completed a continuing recovery care plan developed with the multi-disciplinary team.

☐ Reduction in symptoms as evidenced by:

☐ Attainment of higher level of functioning as evidenced by:

☐ Treatment is no longer medically necessary as evidenced by:

☐ Other:

Person's Signature:			**Date:**
Was the person served provided copy of the IAP? ☐ Yes ☐ No, Reason:			**Person's Initials to confirm:**
Parent/Guardian Signature (if applicable): ☐ N/A	**Date:**	**Supervisor Signature/Credentials (if applicable):** ☐ N/A	**Date:**
Provider Signature/Credentials:	**Date:**	**Physician Signature/Credentials (if applicable):** ☐ N/A	**Date:**
Nurse Signature/Credentials (if applicable): ☐ N/A	**Date:**	**Other Signature/Credentials (if applicable):** ☐ N/A	**Date:**