

## Psychoactive Medication Treatment Plan Annual Continuation of Medication

PRINT CLIENT NAME	DATE OF BIRTH	DATE
ADDRESS	CITY	STATE
SUPPORTING AGENCY		ZIP CODE
TELEPHONE NUMBER		
Description of behavior for which medication is prescribed and mental health diagnosis, if available:		
MEDICATION(S)	DOSAGE AND FREQUENCY	
Positive results of this medication and justification for continuation:		
Plan to continue use of this medication:		
SCHEDULE RETURN VISIT IN:	PRINT NAME OF PERSON COMPLETING FORM	