CONTRA COSTA
BEHAVIORAL HEALTH
A Division of Contra Costa Health Services

Name:

MRN:

Partnership Plan For Wellness
Children's Services
(Physicians and RNs)

This plan is to describe the treatment goals and responsibilities for my child and family.
My (foster) childôs psychiatrist, my (foster) child, and I will work on this plan together and review these goals at least every 6 ï 12 months.

My Child's/Family Strengths:

We will collaborate with our psychiatrist to minimize or eliminate symptoms and to prevent or minimize medication side effects so that my child may better live like others the same age.

Specify goals for my child's treatment may include (√ *all appropriate boxes)*:

- ☐ To feel well
- ☐ To achieve a healthy living environment at home
- ☐ To gain skills that promote independence
- ☐ To fully participate in sports/arts/community activities
- ☐ To enjoy a better social life
- ☐ To do well in school
- ☐ To avoid the need for hospitalization

Additional goals for my childôs treatment:

Strategies we will use to achieve Goals –

- ☐ We will discuss my childôs behavioral challenges and conditions.
- ☐ We will understand and be able to describe at each visit, the potential benefits, risks, and side effects of my childôs medications.
- ☐ We will understand treatment options, including other medications and alternatives to medications and discuss them with the psychiatrist at each visit.
- ☐ We will identify and discuss different steps to improve my childôs health at each visit so that my childôs treatment is safe, specific, and effective.
- ☐ We will recognize and discuss at each visit, side effects of my childôs medications or other concerns my child or I might have regarding my childôs treatment.

(Continued on page 2)

☐ My child will take any medication as prescribed and report to the psychiatrist at each visit any difficulty in doing so.

☐ We both will attend all of our appointments with the psychiatrist.

☐ My child and/or I will attend monthly medication support group.

☐ My child and I will discuss with the psychiatrist whenever my child engages in self-harmful activities and discuss strategies to prevent such activities.

☐ My child and I will identify 3 stressors or events that trigger a crisis and discuss with the psychiatrist at each visit, stressors as they come up.

I can help my childôs treatment by developing a trusting relationship with the psychiatrist. It is important for both my child and me to feel comfortable talking with my childôs doctor about changes in symptoms, concerns about medications, and any side effects that my child experiences.

My signature and my childôs signature on this plan indicate our participation in discussion about its contents.

_____ _____

Parent/Foster Parentôs Signature* Date Psychiatrist Signature Date

_____

Child/Adolescentôs Signature Date

On_____, the parent was offered and: ☐ **received** ☐ **declined** a copy of Partnership Plan.

**If no signature, see progress note dated:* _____

Goals for this treatment added or changed after signature above: (Please date additions or changes.):

My signature and my childôs signature on this plan indicate our participation in discussion about these additions or changes

_____ _____

Parent/Foster Parentôs Signature* Date Psychiatrist Signature Date

_____

Child/Adolescentôs Signature Date

On_____, the parent was offered and: ☐ **received** ☐ **declined** a copy of Partnership Plan.

**If no signature, see progress note dated:* _____