

Clare Mental Health Services weekly Inpatient MDT Care Plan Meeting Page 2

Client Name: _____ Hospital Key Worker _____

Status: _____ Date Completed _____

Attendance---- Please tick box

Patient	Psychiatrist	NCHD	Social Worker	Psychologist
Relatives	Nursing Staff	O. T.	Counsellor	Other

Current Treatment Plan

Identify Needs	How are we going to meet their needs?	Who is going to do it?	By when?	Outcome

Risk Behaviour _____

Discussed with patient after meeting

Comments

Discharge

Est Disch Date: _____

Other agencies to be involved (specify agency and named worker)

Arrange pre-discharge meeting (set date) No / Yes ___/___/___

Carer /Family support to facilitate discharge: _____

GP

Contact Details _____

Clare Mental Health Services MDT Weekly Inpatient Review Care Plan Page 1
Form to be filled in day before MDT meeting

Client Name: _____ Hospital Key Worker _____
 Completed By _____ Title: _____
 Consultant: _____ Status _____ Date completed: _____

To be completed by patient
Emotions, Mood

How are you feeling today? In relation to:

- **Mood:** _____
- **Appetite:** _____
- **Sleep:** _____
- **Energy:** _____

How is your thinking? How are you getting on with?

- **Families/Friends:** _____
- **Others:** _____
- **Staff:** _____
- **Visitors:** _____

Are you improving? Yes No

If yes in what way: _____

If no why? _____

Signature of Client: _____

To be completed by patient and key worker

Worries or concerns

Families/Relationships
 Money
 Drugs or alcohol

Accommodation
 Stressful Events

Comments: _____

Behaviour/Mental State:

Medication

Past History of Compliance
 Adherence / Effectiveness
 Knowledge of meds
 Comments:

Activities and Engagement

Basic Living Skills
 Activation programme in hospital Out of Hospital

Time Out of Hospital and Leave Arrangements

Out Alone _____ Acc Family/Friend/Staff
 Comments on adherence to leave? _____