

Medication Treatment Plan

TEAM CAPTAIN: _____

TEAM MEMBERS: _____

Target Behavior / Symptom:

Medication Name / Dose:

How will I know it is working? (Specific Target behaviors / symptoms)

- 1.
- 2.
- 3.
- 4.

Side Effects to Watch for:

- 1.
- 2.
- 3.
- 4.

If I have concerns call:

911 – Emergency

Clinic Phone:

After Hours / Doctor on Call:

For Refills call: