Individual Recovery/ Care Plan Review Elm Mount Units

All needs/ interventions identified but not completed should be brought Forward to next Plan

Patient's name: _____ **MRN**_____ **Date:** _____ **Time:** _____ **Ward:** _____

Present at MDT: (enter Names)	**Key Worker 1**	**Key Worker 2**
Patient:	Consultant:	Registrar:
Nurse:	CNS:	CBT:
Social Worker:	Psychologist:	O.T.:

Patients strengths identified at Pre-ward round review		
Needs identified	**Interventions (including ward activities and OT)**	**Person Responsible By When**

RELAPSE PREVENTION PLAN

PLANNING DISCHARGE- EARLY WARNING SIGNS IDENTIFIED AND MANAGEMENT PLAN
(Specify other agencies involved)

Ongoing nursing care Needs identified	**Needs/ Interventions not related to patients psychiatric illness (eg; Catheter Care, Weekly weight)**	**Person Responsible**

PROJECTED DISCHARGE DATE: _____

GP CONTACTED **Yes ☐** **No ☐**

Please indicate current risk (as per Risk assessment)

Please circle as appropriate: **LOW** **MEDIUM** **HIGH**

LEAVE STATUS

Please circle as appropriate: **No leave**

Day Leave - hours out **Weekend Leave** **1** **2** **3** **nights**

Other Nights (please specify) _____

Leave Unaccompanied _____

Accompanied by _____

SIGNED ON BEHALF OF

MDT _____
Date / Time

Clothes returned if relevant **Yes ☐** **No ☐**

I wish to receive a copy of my plan **Yes ☐** **No ☐**
I would like my support person to get a copy **Yes ☐** **No ☐**
I agree with my plan **Yes ☐** **No ☐**
If No, Please Specify

_____

_____

_____

Signed By Patient _____
Date/Time