Acute Care Unit Treatment Plan	**Patient Identification** Facility: _____ Offender: _____ GDC ID#: _____ DOB: _____ Race: _____ Sex: _____

Admission Diagnosis: _____

Problem #_____

Goal:

Target Date:

Interventions:	Person Responsible: _____ _____ (Title) Enter Date: _____ Revised/Resolved: _____ Date: _____

Problem #_____

Goal:

Target Date:

Interventions:	Person Responsible: _____ _____ (Title) Enter Date: _____ Revised/Resolved: _____ Date: _____

_____ _____

Patient Signature Date Mental Health Counselor Signature Date

Retention Schedule: Upon completion, this form shall be placed in the offender's mental health file. At the end of the offender's need for mental health services and/or sentence, the mental health file shall be placed within the offender's health record and retained for 10 years.