Crisis Stabilization 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 medical file (Infirmary Section with CSU/ACU packets) and retained for ten (10) years.