FAMILY CARE PLAN: EXTERNALIZING TEMPLATE

Medical Record No. or Stamp

FAMILY CARE PLAN: Externalize Template
(Copy for family and other team members.)

Child's full name: _____ **Date of birth:** _____

Date originated: _____ **Dates revised:** _____ _____ _____ _____

STRENGTHS

_____

_____

PROBLEM AREAS/DIAGNOSES

Problem areas/diagnoses	Diagnostic code	Date/status*	Date/status*	Date/status*
1.				
2.				
3.				

**N = new; W = worsening; O = unchanged; + = improving; R = remission.*

THERAPEUTIC GOALS

Date initiated:	Specifics	Date/status*	Date/status*	Date/status*
☐ **Youth/family goals**				
☐ **Improve safety**	☐ Suicidal thoughts/behavior ☐ Self-injurious behavior ☐ Property destruction ☐ Verbal aggression ☐ Physical aggression ☐ Bullying/bullied ☐ Environment ☐ Weapon/meds ☐ Emergency plan ☐ Other:			
☐ **Improve lifestyle**	☐ Diet ☐ Sleep ☐ Physical activity ☐ Screen time ☐ Outdoor activities ☐ Social contact			
☐ **Improve functioning**	☐ Home ☐ School ☐ Community ☐ Peers ☐ Learning evaluation ☐ Other:			
☐ **Reduce symptoms**	☐ Developmental ☐ Neurologic ☐ Somatic ☐ Mood ☐ Risk behaviors ☐ Anxiety ☐ Disruptive behavior ☐ Other:			
☐ **Improve self-management skills/resilience**	☐ Self-awareness ☐ Self-soothing skills ☐ Self-regulation ☐ Other:			
☐ **Improve communication**	☐ Address conflict within family ☐ Partner with school ☐ Address grief/loss issues within parent/family ☐ Other:			
☐ **Improve understanding of condition/illness/ treatment**	☐ Rec book(s): Hallowell (ADHD) ☐ Rec Web: www.chadd.org ☐ Brochure: Teaching Good Behavior: Tips on How to Discipline ☐ Brochure: How to Handle Anger ☐ Brochure: Parent's Role in Teaching Respect ☐ Brochure: Your Family's Mental Health: 10 Ways to Improve Mood Naturally ☐ Guidelines for Special Time ☐ Other:			
☐ **Prevent/reduce substance use**	☐ Reinforce abstinence or reduction ☐ Monitor ☐ Brief intervention ☐ Referral ☐ Remove alcohol/other substances from home			
☐ **Other:**	☐ Decrease environmental stressors ☐ Reward good behavior ☐ Establish consistent rules ☐ Increase parent's confidence in addressing child's problems ☐ Increase parent's confidence addressing own problems ☐ Seek care from other source(s) ☐ Other:			

**N = new; + = progress toward goal; 0 = no progress toward goal.*

TYPES OF THERAPY AND SUPPORT					
Provider/organization/ family member	**Name/phone**	**Type of care or role***	**Date/status***	**Date/status***	**Date/status***
Parents					
Child care/school personnel		☐ Decrease stressors ☐ Preventive classroom strategies ☐ Management plan for selected problems ☐ Communicate with parents/child ☐ Consider learning evaluation ☐ Other: _____			
Patient		☐ Lifestyle _____ ☐ Management plan for selected problems ☐ Relaxation ☐ Anger management ☐ Communication skills ☐ Problem-solving ☐ Self-management _____ ☐ Other: _____			
Mental health professional(s)		☐ Psychosocial therapy _____ ☐ Med ☐ Other: _____			
Primary care clinician		☐ Care coordination ☐ Med ☐ Facilitate referral(s) ☐ Other: _____			
Agency/other					

*I = individual therapy; F = family therapy; G = group therapy; SA = substance abuse therapy; MHCM = mental health case management; M = mentor program; P = peer support; Med = medication; CC = care coordination through primary care; O = other (specify).

MEDICATIONS			
Name	**Purpose**	**Side effects to monitor**	**Dates dose changed**

☐ *See Psychopharmacologic Medication Flow Sheet.* ☐ *Labs:* _____

Dates: _____

FOLLOW-UP
Next appointment
Emergency contact

Clinician's signature/date: _____

Initials/date reviewed: _____ _____ _____ _____ _____

Parent/guardian signature/date:

Initials/date reviewed: _____ _____ _____ _____ _____

Youth's signature/date: _____

Initials/date reviewed: _____ _____ _____ _____ _____