

Major Depressive Disorder Treatment Plan

Patient information		
Name:	Age:	Sex:
Date of birth:		
Phone number:		
Date of consultation:		
Diagnosis:		
Symptoms:		
Assessment results:		
Treatment goals		
Short-term goals:		
Long-term goals:		

Intervention**Recommended medication (if applicable)****Progress notes**

Client signature:

Date:

Healthcare provider's information

Name:

ID number:

Contact details:

Signature: