Major Depressive Disorder Treatment Plan

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