**Interdisciplinary Plan of Care (IPOC) for Office Based Addiction Treatment (OBAT) Providers and Opioid Treatment Programs (OTP)**

**Last Updated October 5, 2022**

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| **MEMBER INFORMATION** | | | | | | | | | |
| Name: | | | | | | Preferred Name: | | | DOB: |
| MRN: | | | If retroactively enrolled, provide enrollment date: | | | | | | |
| Medical Record Number: |  | | | | | | | | |
| Name of Health Plan: |  | | | | | | | | |
| Family or Legally Authorized Representative: | | | | | | | | | |
| Primary Care Physician: | | | | | Consent to Release Completed | | | | |
| **PRESENTING ISSUES / Primary diagnosis(es)** | | | | | | | | | |
| 1. | | 2. | | | | | 3. | | |
| **recovery milestones / disharge plan** | | | | | | | | | |
|  | | | | | | | | | |
| **Interdisciplinary Plan of Care (IPOC) INFORMATION** | | | | | | | | | |
| IPOC Review Date:  (within 30 calendar days of ISP assessment) | | | | Next IPOC Review Due Date:  Ongoing every 30 calendar days | | | | | |
| **ipoc participants At Interdisciplinary treatment team meetings – Designated substance use care coordinator must compete the IPOC** | | | | | | | | | |
| **TITLE** | | | **PRINT NAME** | | | **SIGNATURE** | | **team meeting and review date** | |
| Designated Substance Use Care Coordinator | | |  | | |  | |  | |
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| **MEMBER/GUARDIAN/NEXT OF KIN/SIGNIFICANT OTHER INVOLVEMENT:** | | | | | | | | | |

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| --- | --- |
| Staff will review the IPOC with the Member, Guardian, Next of Kin, and/or Significant Other as appropriate.  Member Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ | |
| The Member: | Agrees to the plan of care  Agrees to the plan of care, but does not wish to sign  Disagrees with the plan of care  Member is on precautions and verbally agrees /disagrees  Unable to discuss due to a psychiatric or medical condition  Other: |
| The Guardian/Next of Kin/Significant Other: | Is participating with the member’s plan of care  Is not participating with the member’s plan of care  Other: |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **assessment/**  **focus area** | **problems/Needs** | **objectives** | **Interventions** | **progress Since last interdisciplinary treatment team meeting** |
| Medical | Referral to Primary Care  Referral to Specialty Care if needed (e.g., Hepatology)  Family Planning  Other |  |  |  |
| Psychological |  |  |  |  |
| Readiness to Change |  |  |  |  |
| Relapse, Continued Use, or Continued Problem Potential |  |  |  |  |
| Recovery/ Living Environment | Housing  Employment  Legal  Food  Child Care  Finances  Transportation  Other |  |  |  |
| Care Coordination | Referral to AA/NA  Referral to Peer Services  Other |  |  |  |