

FLORIDA DEPARTMENT OF CORRECTIONS Individualized Service Plan

Problem Name			Problem #	
Problem Description in Behavioral Terms			Problem Frequency, Duration & Intensity	
Treatment Goal: (Target behaviors in measurable terms)				
Interventions	Intervention Frequency (or N/A)	Intervention Provider (Specify each by name and title)		
Case Management				
Individual Counseling				
Psychiatric Follow Up				
Medication Management				
Group Counseling:				
Other:				
Other:				

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Inmate Name _____
 DC# _____ R/S _____
 Date of Birth _____
 Institution _____

Current S-Grade: _____ MDST Date: _____

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ICD-10 Diagnosis (code and description)	1		5	
	2		6	
	3		7	
	4		8	

Alerts: self-harm/suicide attempts, assaults, escapes, etc.

Summary Of Institutional Adjustment

Summary Of Treatment Compliance and Progress

Other Treatment Related Information & Deferred Problems

Rationale for any ISP Changes

Signatures:

_____	_____	_____	_____
Sr. Behavioral Analyst	Date	Case Manager	Date
_____	_____	_____	_____
Nursing Representative	Date	Psychiatrist	Date
_____	_____	_____	_____
Correctional Officer	Date	Other (specify)	Date
_____	_____	_____	_____
Inmate Patient	Date	Other (specify)	Date

Target Date (Next Review Date)	_____
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