YOUR TREATMENT PLAN

Patient Name: _____ **Date:** _____

Depression Care Manager: _____ **Phone:** _____

Next Appointment: **Date:** _____ **Time:** _____

Your Medication Schedule

1. _____ **First:** take _____ tablet(s) of _____ mg for _____ days
   Then: take _____ tablet(s) of _____mg for _____ days
2. _____ **First:** take _____ tablet(s) of _____ mg for _____ days
   Then: take _____ tablet(s) of _____mg for _____ days
3. _____ **First:** take _____ tablet(s) of _____ mg for _____ days
   Then: take _____ tablet(s) of _____mg for _____ days

NOTE: The medication is started at a low dose to give your body time to adapt. If you are having side effects, you can stay at a lower dose for a little longer, then increase the amount.

Remember: It may take a few weeks before you experience the medication's full effect, so don't get discouraged. *DO NOT STOP THE MEDICATION BEFORE CALLING YOUR DEPRESSION CARE MANAGER OR OB-GYN PROVIDER.*

Your Problem Solving Treatment (PST-PC)

1. _____
2. _____
3. _____

Your Pleasurable Activity Schedule (be as specific as possible: what, when, how?)

1._____
2._____
3. _____