Treatment Plan Review Cheat Sheet

Reviewed by the BastionGPT Clinical Advisory Board · July 2026

A treatment plan review is the periodic note that measures progress against each goal in the active treatment plan, records barriers and new clinical information, and ends in a decision: continue unchanged or update. Most run 150 to 500 words.

1 – Header and plan linkage the version trail auditors follow
Do: date the review; identify the plan version under review and the period covered.
Pitfall: a review that never says which plan it reviews.

2 – Participation who took part, and how
Do: record client and team involvement and how the client's input was gathered.
Pitfall: nothing showing understanding, involvement, and agreement where a program requires it.

3 – Progress toward each goal the plan's own measures
Do: give per-goal status with the measure the plan set: scores, attendance, function.
Pitfall: one global "client is doing well" line with no per-goal evidence.

4 – Barriers and new information symptoms, access, life events
Do: name what interfered, plus any diagnosis, risk, or medication change.
Pitfall: barriers listed with no plan response.

5 – Continued medical necessity why care continues at this dose
Do: state remaining impairment, regression risk, or the maintenance rationale, and any step-down criteria.
Pitfall: progress documented so well the note undercuts necessity.

6 – Decision: change or no-change rationale a review may conclude "continue"
Do: revise goals, dates, or frequency; or give the evidence for continuing unchanged.
Pitfall: re-signing the same text each cycle; cloned reviews read as no review.

7 – Signatures, dates, next review close the loop
Do: sign with credentials; collect required client or supervisor signatures; set the next review date.
Pitfall: unsigned or undated reviews; signature gaps are a top federal audit finding.

Before you sign

- ☐ Names the plan version it reviews
- ☐ Per-goal status uses the plan's measures
- ☐ Every barrier meets a plan response
- ☐ Necessity stated: impairment, risk, or maintenance
- ☐ Participation and required signatures documented
- ☐ Next review date set

Drafting with AI

Give it the active plan plus your progress notes or bullets: per-goal scores, barriers, medication and risk status, what changes.

> *"Draft a treatment plan review from this plan and these six progress notes: PHQ-9 17 to 11, work goal stalled (employer restructuring), meds unchanged: …"*

Never paste client-identifying information into consumer AI tools. BastionGPT is HIPAA-compliant with a signed BAA on every plan.

150–500 words	10–20 min by hand	On your program's cadence	Client · payers · auditors
typical length	clinical team estimate	when it's written	who reads it

Full guide, sample review, and compliance notes:
bastiongpt.com/template/treatment-plan-review

Treatment Plan Review Template

Copy or print for your practice · Adapt fields to your organization's, payer's and jurisdiction's documentation requirements.

Client (initials): | Review date: | Review #:

Plan under review (date/version): | Period covered:

Participants and client input

Who took part; how the client's input was gathered; agreement or disagreement

Goal 1: progress and status

Status (met / progressing / no change / regressed) with the plan's own measure and evidence

Goal 2: progress and status

Add rows per goal; every goal in the plan gets a status

Barriers and new clinical information

Diagnosis, risk, or medication changes; pair each barrier with a response

Continued medical necessity

Remaining impairment, regression risk, or maintenance rationale; step-down criteria

Plan changes (or rationale for no change)

Revised goals, objectives, target dates, frequency; or the evidence for continuing unchanged

Next review date: | Review cadence set by:

Clinician signature / credentials: | Date signed:

Client signature, where required: | Date:

Supervisor signature, where required: | Date: