§ 29.13 Treatment plans.

(a) Subject to the regulations of the commissioner, the director of each departmental facility shall require the development of a written treatment plan to assure adequate care and treatment for each patient.

(b) The written treatment plan shall include, but not be limited to, a statement of treatment goals; appropriate programs, treatment or therapies to be undertaken to meet such goals; and a specific timetable for assessment of patient programs as well as for periodic mental and physical reexaminations. In causing such a plan to be prepared or when such a plan is to be revised, the following persons shall be interviewed and provided an opportunity to actively participate in such preparation or revision: the patient; an authorized representative of the patient, to include the parent or parents if the patient is a minor, unless such minor sixteen years of age or older objects to the participation of the parent or parents and there has been a clinical determination by a physician indicating that the involvement of the parent or parents is not clinically appropriate and such determination is documented in the record; upon the request of the patient sixteen years of age or older, a significant individual to the patient including any relative, close friend or individual otherwise concerned with the welfare of the patient, other than an employee of the facility.