Rejection Sensitivity Treatment Plan

Patient information			
Name:		**Age:**	
Gender:		**Plan start date:**	
Rejection sensitivity history			
Current symptoms:		**Duration/onset:**	
History of rejection sensitivity:			
Treatment goals			
Short-term goals:		**Long-term goals:**	
Treatment interventions			
Intervention	**Focus area/s**	**Description**	**Remarks**

Coping strategies		
Coping strategy	**Description/instructions**	**Remarks**

Medications

Additional notes

Healthcare professional: _____ **Signature:** _____