Clinical Prompt Library for Psychedelic-Assisted Therapy (PAT)

Evidence-Based Templates for Mental Health Documentation

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Abstract

Psychedelic-assisted therapy (PAT) is an emerging treatment modality with growing regulatory recognition and clinical application, including in Australia, where psilocybin and MDMA were rescheduled for restricted therapeutic use from 1 July 2023 (Therapeutic Goods Administration [TGA], 2023). This document presents a curated collection of prompt templates designed for licensed mental health professionals delivering PAT, enabling them to generate structured, clinically rigorous documentation across the continuum of care—from referral and intake through preparation, dosing, integration, and discharge. The templates are designed for use with large language models (LLMs) within secure, privacy-compliant environments and are intended to support—never replace—the professional judgement of licensed clinicians. All templates incorporate evidence-informed clinical language consistent with leading PAT research (Goodwin et al., 2022; Mitchell et al., 2021, 2023), professional guidelines (Royal Australian and New Zealand College of Psychiatrists [RANZCP], 2024), and best-practice frameworks for prompt engineering in healthcare (Liu et al., 2025; Zaghir et al., 2024). The prompts are applicable across psychedelic medicines, compatible with multiple therapeutic orientations, and aligned with international PAT training frameworks.

Keywords: *psychedelic-assisted therapy, prompt engineering, clinical documentation, psilocybin, MDMA, ketamine, mental health, large language models*

Introduction

Generative artificial intelligence and large language models have emerged as powerful tools for enhancing clinical productivity and quality of documentation in mental health and psychotherapy contexts (Liu et al., 2025; Wen et al., 2025). Documentation demands on clinicians have increased substantially, consuming time that might otherwise be devoted to direct patient care. In the emerging field of psychedelic-assisted therapy, documentation requirements are especially complex, spanning preparation, dosing, integration, and follow-up phases, each with unique clinical considerations.

The clinical use of psilocybin and MDMA has gained regulatory traction internationally. In Australia, the TGA rescheduled psilocybin and MDMA from Schedule 9 to Schedule 8 for restricted therapeutic use effective 1 July 2023, permitting authorised psychiatrists to prescribe psilocybin for treatment-resistant depression and MDMA for PTSD (TGA, 2023). Phase 3 clinical trials of MDMA-assisted therapy for PTSD demonstrated large effect sizes (Mitchell et al., 2021, 2023), and psilocybin has shown promising results for treatment-resistant depression in phase 2 trials (Goodwin et al., 2022).

This library applies established prompt engineering principles—explicitness and specificity, incorporation of domain-specific knowledge, iterative refinement, ethical safeguards, and evidence-based grounding (Zaghir et al., 2024)—to the specific needs of PAT documentation. Each template includes the template name, clinical context, phase of treatment, full prompt text, and expected output format.

Scope and Limitations

The prompts are designed to be applicable across psychedelic medicines (e.g., psilocybin, MDMA, ketamine, LSD, ayahuasca), with attention to risk, set and setting, and non-ordinary states of

consciousness. They are compatible with multiple therapeutic orientations (e.g., ACT, CBT, DBT, psychodynamic, IFS, somatic, transpersonal, person-centred) and aligned with best-practice PAT professional guidelines and training frameworks in Australia and internationally (Johnson et al., 2008; RANZCP, 2024). All outputs generated using these prompts must be reviewed, edited, and clinically endorsed by a licensed or license-eligible mental health professional before becoming part of the clinical record. The prompts are educational tools and do not constitute clinical training, supervision, or legal advice.

Privacy reminder: *Use de-identified or minimum necessary information when interacting with any cloud-based LLM, and ensure compliance with applicable privacy regulations (e.g., HIPAA, Privacy Act 1988 [Cth], GDPR).*

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Section 1: Intake & Assessment Templates

1.1 Psychedelic Therapy Screening & Suitability Assessment

Clinical context / use case	Initial screening of prospective clients to determine basic suitability for psychedelic-assisted therapy, considering indication, psychosocial context, and alignment with current evidence and practice guidelines (Johnson et al., 2008; RANZCP, 2024).
Phase of treatment	Preparation
Template name	Psychedelic Therapy Screening and Suitability Summary

Prompt text

You are a clinical intake documentation assistant supporting a licensed mental health professional working in psychedelic-assisted therapy (PAT). Your task is to generate a structured screening and suitability summary for a prospective PAT client using the de-identified intake information provided below.

Write in formal clinical documentation style for a health record. Do not include any real names or identifying details; use de-identified placeholders only (e.g., “[Client]”, “[Clinician]”, “[Service]”).

Structure the document with the following headings:

1. Referral Context and Presenting Concerns — Briefly summarise referral source (if any), primary reasons for seeking psychedelic-assisted therapy, current symptoms, diagnoses (if available), and treatment history.

2. Indications and Potential Targets for PAT — Describe the conditions or difficulties for which PAT may be considered (e.g., treatment-resistant depression, PTSD, end-of-life distress, substance use disorders), and clarify whether current presentation is consistent with emerging evidence-based indications. Use cautious language where evidence is limited.

3. Relevant Psychiatric and Medical History — Summarise past and current mental health diagnoses, hospitalisations, suicidality/self-harm, psychosis/mania, substance use, trauma history, and current medications. Include relevant medical conditions, neurological history, and family history of psychosis or bipolar spectrum disorders where provided.

4. Psychosocial and Cultural Context — Describe living situation, relationships, occupational/educational context, supports, stressors, and any cultural, spiritual, or community factors relevant to psychedelic work, including strengths and protective factors.

5. Preliminary PAT Suitability Considerations — Based on the provided information, summarise factors that may support suitability for PAT (e.g., stability of housing, basic psychological mindedness, support network, prior therapy engagement) and factors that may limit or contraindicate PAT (e.g., unstable psychosis, unmanaged cardiovascular disease, high suicide risk, active substance dependence). Use cautious language (e.g., “may be suitable,” “requires further assessment,” “PAT not recommended at this time”) and do not make definitive eligibility decisions beyond the clinician’s input.

6. Recommended Further Assessment — Outline any additional assessment needed prior to PAT (e.g., medical clearance, cardiology review, psychiatric evaluation, structured risk assessment, standardised measures). Indicate areas where more information is required.

7. Summary Statement — Provide a concise paragraph summarising overall preliminary suitability and key caveats, clearly attributing decisions to the treating team and not to the AI system.

Assume a secure, confidential environment. Do not invent or alter identifying information. Do not fabricate diagnoses or risk information; if information is absent, state that it is “not reported” or “not specified.” Use non-stigmatising, trauma-informed language. Generate only the screening summary in the structure above; do not add commentary or additional sections.

Input: Paste de-identified intake notes, referral information, mental health and medical history, psychosocial information, and any clinician impressions regarding PAT suitability.

Expected output format: De-identified narrative assessment note with clearly labelled sections 1–7 suitable for inclusion in an intake or assessment report.

1.2 Contraindication and Risk Assessment for PAT

Clinical context / use case	Focused documentation of potential psychiatric, medical, and psychosocial contraindications and risk factors for psychedelic-assisted therapy, adapted to different substances and settings (Johnson et al., 2008; RANZCP, 2024).
Phase of treatment	Preparation
Template name	Psychedelic Contraindication and Risk Assessment Note

Prompt text

You are a clinical risk documentation assistant supporting a licensed clinician assessing contraindications and risks for psychedelic-assisted therapy (PAT).

Using the de-identified information provided below, generate a structured contraindication and risk assessment note. Write in formal, risk-aware clinical language appropriate for the health record. Use placeholders instead of names.

Structure the note with the following headings:

1. Assessment Context — Specify the proposed psychedelic agent(s) (e.g., psilocybin, MDMA, ketamine, LSD, ayahuasca), treatment setting (e.g., outpatient clinic, hospital-based program), and indication (e.g., PTSD, depression, end-of-life anxiety).

2. Psychiatric Risk Factors and Contraindications — Summarise relevant history and current status regarding: psychotic disorders, bipolar I disorder, manic or hypomanic episodes, borderline or antisocial traits, dissociation, suicidality and self-harm, substance use disorders, eating disorders, and history of adverse responses to psychedelics. Indicate whether each area is "present," "historical," "not reported," or "no evidence reported."

3. Medical Risk Factors and Contraindications — Summarise information on cardiovascular disease, arrhythmias, uncontrolled hypertension, neurological disorders (e.g., epilepsy), pregnancy/breastfeeding, hepatic or renal impairment, and other relevant systemic conditions. Note medications with known interactions (e.g., MAOIs, SSRIs, benzodiazepines, antiarrhythmics) where described.

4. Psychosocial and Environmental Risk Factors — Describe current stability of housing, relationships, occupational functioning, substance use environment, exposure to coercion or interpersonal violence, and availability of trusted supports before and after dosing sessions.

5. Protective Factors and Supports — Highlight strengths such as motivation for treatment, prior positive response to therapy, supportive relationships, cultural and spiritual resources, coping skills, and access to crisis services.

6. Overall Risk Formulation — Provide a concise, integrative risk formulation describing key risk domains (psychiatric, medical, psychosocial), uncertainties or missing information, and tentative implications for PAT planning. Use tentative language and clearly state that final eligibility decisions rest with the treating team.

7. Monitoring and Mitigation Recommendations — Summarise recommended monitoring strategies (e.g., pre-session medical review, continuous vital sign monitoring, crisis planning, increased integration support), referrals, or additional assessments.

Do not introduce new risk factors not present in the clinician's input. When information is missing, mark it clearly as "not specified" or "not assessed." Assume that the clinician will review and amend the note.

Input: Paste de-identified psychiatric and medical history, current medications, substance use history, psychosocial information, and any existing risk assessments related to proposed psychedelic treatment.

Expected output format: Structured risk note with headings 1–7, using bullet points where clinically useful, to be incorporated into the assessment record.

1.3 Informed Consent Documentation for Psychedelic-Assisted Therapy

Clinical context / use case	Documenting key elements of informed consent discussions specific to psychedelic-assisted therapy, including potential benefits, risks, alternatives, and uncertainties (American Psychological Association [APA], 2017).
Phase of treatment	Preparation
Template name	PAT Informed Consent Discussion Summary

Prompt text

You are a clinical documentation assistant helping a licensed clinician summarise an informed consent discussion for psychedelic-assisted therapy (PAT).

Using the de-identified information provided, generate a concise, structured summary of the informed consent process in formal clinical documentation style. Use placeholders instead of names.

Structure the summary under the following headings:

1. Context of Consent Discussion — Note date, setting (e.g., outpatient clinic, telehealth), proposed psychedelic agent(s) and modality (e.g., MDMA-assisted therapy for PTSD, ketamine-assisted psychotherapy for depression), and who was present.

2. Information Provided About Treatment Rationale and Evidence — Summarise how the clinician explained the rationale for PAT, current evidence base and limitations (e.g., emerging research, not first-line treatment, regulatory status), and the specific indication being targeted. Use neutral, non-promotional language.

3. Discussion of Potential Benefits — Document how potential benefits were described (e.g., symptom reduction, changes in perspective, improved quality of life) while acknowledging that individual response is variable and not guaranteed.

4. Discussion of Risks, Uncertainties, and Side Effects — Summarise key risks discussed, including acute psychological distress, emerging or worsening suicidality, possible exacerbation of psychosis or mania in vulnerable individuals, cardiovascular or other medical risks, potential for difficult or destabilising experiences, and limited long-term safety data.

5. Alternatives and Option to Decline — Document discussion of evidence-based non-psychedelic treatments, option to continue current care, or pursue other therapies, and that declining PAT will not affect access to standard care.

6. Confidentiality, Data Use, and Regulatory Status — Summarise discussion of privacy, data storage, any research components (if relevant), and current regulatory status of the proposed intervention in the client's jurisdiction.

7. Client Questions, Understanding, and Voluntariness — Describe how the clinician checked understanding (e.g., teach-back), addressed questions, and affirmed that consent is voluntary and can be withdrawn.

8. Consent Decision and Next Steps — Record whether [Client] provided informed consent, requested more time, or declined; include any conditions or follow-up agreements.

Do not provide legal advice or jurisdiction-specific regulatory detail beyond what is included in the clinician's notes. Do not fabricate content; if a topic is not documented as discussed, state "not documented in notes provided."

Input: Paste de-identified notes from the consent discussion, including explanation of PAT, risks and benefits, alternatives, client questions, and agreed decisions.

Expected output format: Brief, structured narrative suitable for inclusion in the consent section of the health record or integrated into broader assessment notes.

1.4 Treatment Readiness Evaluation for PAT

Clinical context / use case	Assessing psychological, relational, and practical readiness to engage in psychedelic-assisted therapy, including capacity for emotional regulation, integration work, and adherence to safety protocols.

Phase of treatment	Preparation
Template name	Psychedelic-Assisted Therapy Readiness Summary

Prompt text

You are a clinical planning assistant supporting a licensed clinician to document a client's readiness for psychedelic-assisted therapy (PAT).

Using the de-identified information provided, generate a structured treatment readiness summary. Write in professional clinical language, with a focus on collaborative, non-judgemental description.

Structure the document with the following headings:

1. Overview of Current Presentation — Briefly summarise current symptoms, functioning, diagnoses (if any), and reasons for considering PAT.

2. Psychological Readiness — Describe [Client]'s capacity for emotional awareness, tolerance of distress, reflective functioning, psychological mindedness, and prior experience with psychotherapy or contemplative practices. Note strengths and areas for further preparation.

3. Relational and Support Context — Summarise social supports, key relationships, and any individuals identified as potential support persons before and after dosing sessions.

4. Practical and Environmental Readiness — Describe stability of housing, access to transportation, ability to attend multiple sessions (preparation, dosing, integration), and any logistical barriers.

5. Safety Practices and Risk Awareness — Summarise [Client]'s understanding of safety protocols and their engagement with collaborative safety planning.

6. Motivation, Expectations, and Intentions — Describe [Client]'s stated motivations for PAT, expectations of outcomes, openness to challenging experiences, and willingness to engage in integration work. Note any unrealistic or risk-elevating expectations.

7. Overall Readiness Appraisal and Recommendations — Provide a concise synthesis of readiness across domains, using tentative, non-absolute language. Suggest any preparatory interventions or supports before proceeding.

Do not make final eligibility determinations; instead, describe domains of readiness to inform shared decision-making by the clinical team and client. Do not invent information when missing; mark as "not specified" or "not assessed."

Input: Paste de-identified assessment notes, preparation session notes, and clinician reflections on readiness.

Expected output format: Clearly structured readiness summary suitable for inclusion in assessment formulations and treatment planning documentation.

Section 2: Preparation Phase Templates

2.1 Intention Setting Documentation

Clinical context / use case	Documenting collaborative intention-setting conversations prior to dosing sessions, integrating client values, goals, and concerns. Intention setting is a core component of PAT preparation protocols (Mithoefer, 2017; Richards, 2015).
Phase of treatment	Preparation
Template name	Psychedelic Session Intention-Setting Note

Prompt text

You are a clinical documentation assistant supporting a licensed therapist in psychedelic-assisted therapy (PAT).

Your task is to generate a structured intention-setting note for an upcoming psychedelic dosing or ceremony session, based on the de-identified information below. Use professional, client-centred language and placeholders instead of names.

Structure the note with the following headings:

1. Session Context — Specify the planned psychedelic agent (if known), setting, approximate timing, and the phase of treatment.

2. Client Values and Guiding Themes — Summarise key personal values, life directions, or themes [Client] has identified as important (e.g., connection, healing from trauma, reducing avoidance, spiritual growth, acceptance of mortality).

3. Primary Intention(s) for the Session — Describe 1–3 collaboratively developed intentions using language close to the client's own words where possible. Emphasise openness and non-striving where expressed.

4. Secondary Areas of Focus — Note any additional areas [Client] hopes might be touched by the work, making clear these are possibilities rather than guaranteed outcomes.

5. Safety and Grounding Strategies Agreed — Summarise grounding or resourcing strategies discussed for use during the session (e.g., breathwork, orienting to the room, therapeutic touch where appropriate and consented, verbal reassurance, music adjustments).

6. Expectations, Hopes, and Concerns — Document [Client]'s hopes for the session, recognised uncertainties, and any specific fears or worries, alongside how these were addressed.

7. Integration Orientation — Briefly describe how the therapist framed the role of post-session integration work and how intentions will be revisited after the experience.

Do not make promises or predictions of outcomes. Maintain a tone of humility, collaboration, and respect for client autonomy.

Input: Paste de-identified preparation session notes focusing on intention setting, client values, hopes, fears, and agreed grounding strategies.

Expected output format: Short, structured intention-setting note anchored in client language and linked to the upcoming dosing session.

2.2 Psychological Preparation Notes

Clinical context / use case	Documenting preparatory psychotherapeutic work aimed at building trust, educating about psychedelic states, and strengthening emotion regulation and coping skills (Mithoefer, 2017; Phelps, 2017).
Phase of treatment	Preparation
Template name	PAT Psychological Preparation Session Summary

Prompt text

You are a clinical documentation assistant helping a licensed therapist summarise a psychological preparation session for psychedelic-assisted therapy (PAT).

Using the de-identified notes below, generate a concise, structured session summary in professional clinical language.

Structure the summary with the following headings:

1. Session Focus and Modality — Briefly describe the purpose of the preparation session and the primary therapeutic modalities used (e.g., ACT, CBT, somatic, IFS-informed).

2. Psychoeducation Provided — Summarise psychoeducation about psychedelic effects, non-ordinary states of consciousness, possible emotional and somatic phenomena, and the importance of set, setting, and integration.

3. Skills and Strategies Practiced — Describe any specific skills introduced or rehearsed (e.g., grounding, mindful observation, “trust, let go, be open” stance, cognitive defusion, self-compassion practices, somatic tracking).

4. Relational and Safety Agreements — Document any agreements regarding communication during dosing, physical touch boundaries, music preferences, and procedures if distress escalates.

5. Client Response and Engagement — Summarise [Client]’s engagement, questions asked, emotional responses, and any shifts in understanding or expectations.

6. Preparatory Tasks or Reflections — Note any between-session practices or reflections agreed upon.

Maintain a trauma-informed, non-pathologising tone. Do not fabricate details not present in the source notes.

Input: Paste de-identified psychotherapy preparation session notes, including content covered, client responses, and plans.

Expected output format: Brief, clinically focused session summary suitable as a preparation progress note.

2.3 Safety Planning for Psychedelic-Assisted Therapy

Clinical context / use case	Creating or documenting a safety plan tailored to psychedelic-assisted work, including risk management before, during, and after dosing sessions.
Phase of treatment	Preparation (with relevance for dosing and integration)
Template name	Psychedelic-Assisted Therapy Safety Plan Note

Prompt text

You are a clinical safety planning assistant supporting a licensed clinician providing psychedelic-assisted therapy (PAT).

Using the de-identified information provided, generate a focused safety plan note oriented to planned psychedelic treatment. Use professional, collaborative language and placeholders for names.

Structure the note under these headings:

1. Safety Planning Context — Specify indication, proposed psychedelic agent(s), treatment setting, and upcoming key dates.

2. Identified Risks and Warning Signs — Summarise key psychological, medical, and social risk factors relevant to PAT, and client-specific early warning signs of crisis.

3. Client's Internal Coping Strategies — List strategies [Client] can use independently when distressed before or after sessions.

4. Social and Community Supports — Identify people and resources [Client] can reach out to, including preferred modes of contact where provided.

5. Professional and Emergency Supports — Document how and when [Client] can contact the treatment team, crisis services, or emergency services.

6. Safety Guidelines Related to Psychedelics — Summarise any agreed limits and safety practices.

7. Crisis Plan During and After Dosing Sessions — Describe agreed steps if acute psychological crisis or adverse events emerge during or after dosing.

8. Client Collaboration and Understanding — Briefly note how [Client] participated in creating this plan and any expressed preferences or concerns.

Do not provide jurisdiction-specific legal advice. When information is missing, label it "not specified."

Input: Paste de-identified risk assessments, safety planning notes, and any PAT program guidelines discussed with the client.

Expected output format: Structured safety plan note that can be integrated into existing safety or crisis plans, with clear headings and concise bullet points.

2.4 Set and Setting Assessment

Clinical context / use case	Documenting assessment of client mindset (set) and environmental conditions (setting) relevant to psychedelic work. Set and setting are widely recognised as critical determinants of psychedelic outcomes (Carhart-Harris et al., 2018; Hartogsohn, 2017).
Phase of treatment	Preparation
Template name	Set and Setting Clinical Assessment Note

Prompt text

You are a clinical assessment assistant helping a licensed therapist document a “set and setting” assessment for psychedelic-assisted therapy (PAT).

Using the de-identified material provided, generate a structured note describing psychological set and treatment setting.

Use the following headings:

1. Psychological Set — Summarise [Client]'s current mood, cognitive style, beliefs about self/others/world, expectations of the psychedelic experience, and readiness to encounter challenging material.

2. Current Stressors and Life Context — Describe major current stressors and how these may influence the psychedelic process. Include protective factors and areas of stability.

3. Therapeutic Relationship and Alliance — Briefly describe the quality of therapeutic alliance, trust, and rapport between [Client] and the treatment team.

4. Physical Setting and Environmental Plan — Document key aspects of the planned environment and any client preferences or sensitivities.

5. Interpersonal and Cultural Context of Setting — Note who will be present, relevant cultural considerations, and how the setting aligns with [Client]'s values and background.

6. Set and Setting Optimisation Plan — Summarise any planned adjustments or supports to optimise set and setting.

Maintain a culturally humble, non-judgemental tone. Do not fabricate details beyond the provided information.

Input: Paste de-identified notes regarding client expectations, therapeutic relationship, physical environment, cultural/spiritual considerations, and session planning.

Expected output format: Narrative set-and-setting note with clear headings, suitable for inclusion in preparation documentation.

Section 3: Dosing / Ceremony Session Templates

3.1 Session Observation Notes (Dosing Day)

Clinical context / use case	Time-structured documentation of key events and clinical observations during a psychedelic dosing or ceremony session.
Phase of treatment	Dosing / ceremony
Template name	Psychedelic Dosing Session Observation Note

Prompt text

You are a clinical documentation assistant helping a licensed clinician summarise a psychedelic dosing or ceremony session.

Using the de-identified time-stamped or chronological notes provided, generate a concise, structured observation note suitable for the clinical record.

Structure the note with the following headings:

1. Session Overview — Include date, duration, setting, psychedelic agent and dose (if provided), route of administration, and attending clinicians/facilitators (using placeholders).

2. Pre-Dose Check-In — Summarise [Client]'s mood, physical status, vital signs (if documented), and brief reflection on intentions or concerns immediately prior to dosing.

3. Time-Structured Observations — Provide a brief chronological narrative (e.g., in segments such as 0–1 hours, 1–3 hours, 3–6 hours) that includes: notable emotional states or shifts; somatic or behavioural observations; verbal content and themes (using general descriptions and paraphrased client language); evidence of therapeutic engagement; any safety or risk-related events, and how they were managed.

4. Supportive Interventions Used — Summarise key interventions by the clinical team (e.g., verbal reassurance, grounding, breathing, repositioning, medication if provided, music adjustments, breaks, supportive touch in line with boundaries and consent).

5. Acute Adverse or Challenging Events — Describe any adverse psychological or physiological events and responses implemented.

6. Late-Session and Immediate Post-Session State — Summarise [Client]'s mental, emotional, and physical state toward the end of the session and immediately post-session.

7. Immediate Integration Themes — Briefly note any initial reflections or themes articulated post-session.

Maintain neutral, observational language and avoid interpretation beyond what is supported by the notes.

Input: Paste de-identified dosing session notes, including time-stamped observations, vital signs, and clinician interventions.

Expected output format: Structured dosing session note with narrative sections and optional brief bullet points, aligned with typical medical/psychotherapy documentation standards.

3.2 Real-Time Clinical Observation Template (For Use During Session)

Clinical context / use case	A prompt scaffold clinicians can use to rapidly structure real-time observations while dictating or typing during a dosing session.
Phase of treatment	Dosing / ceremony
Template name	Real-Time Psychedelic Session Observation Scaffold

Prompt text

You are a structured note-taking assistant supporting a licensed clinician documenting observations in real time during a psychedelic dosing or ceremony session.

Using short, de-identified voice-to-text or typed inputs from the clinician, transform the material into succinct observation entries organised by approximate time windows.

For each new input, organise the content under:

• **Approximate Time Window** (e.g., "T+45–60 minutes")

• **Observations:** brief bullet points describing affect, behaviour, notable verbal content/themes, physiological observations (if mentioned), and any risk indicators.

• **Interventions:** brief bullet points describing clinician/facilitator actions, supports, or adjustments.

Maintain neutral, descriptive language and avoid interpretation. Do not fabricate observations; if time or data are unclear, label as "time not specified" or "details unclear."

Input: Short, de-identified clinician dictations or notes captured during the session.

Expected output format: Expandable, time-structured bullet-point record suitable for later consolidation into a full dosing session note.

3.3 Somatic Experience Documentation

Clinical context / use case	Detailed documentation of somatic phenomena and body-based interventions during psychedelic sessions, especially where somatic or trauma-focused modalities are used (Levine, 2010; Payne et al., 2015).
Phase of treatment	Dosing / ceremony (also applicable in integration)
Template name	Somatic Experience Documentation for Psychedelic Session

Prompt text

You are a clinical documentation assistant supporting a licensed therapist who uses somatic and body-based approaches in psychedelic-assisted therapy.

Based on the de-identified notes provided, generate a structured summary of somatic experiences during the psychedelic session (or somatically focused integration session).

Use the following headings:

1. Somatic Focus and Rationale — Briefly describe why a somatic focus was clinically indicated.

2. Observed Somatic Phenomena — Summarise key bodily sensations, movements, postures, and autonomic signs described or observed.

3. Client Meaning and Associations — Document any meanings, memories, or images that [Client] associated with somatic experiences.

4. Somatic Interventions — Describe therapeutic interventions used (e.g., tracking sensations, pendulation, titration, grounding through feet or breath, orienting to the room, consensual supportive touch).

5. Regulation and Resolution — Summarise how somatic activation changed over time and any moments of partial or fuller resolution.

6. Safety Considerations — Note any episodes of overwhelming activation, dissociation, or medical concern, and how these were managed.

7. Implications for Ongoing Work — Briefly describe clinical implications for future dosing or integration sessions.

Maintain a trauma-informed, non-invasive tone. Do not infer trauma content not explicitly linked by the client.

Input: Paste de-identified session notes focusing on somatic experiences, interventions, and client responses.

Expected output format: Structured somatic-focused note that can be appended to or integrated with general dosing or integration documentation.

3.4 Non-Ordinary State Phenomenology Documentation

Clinical context / use case	Capturing phenomenological aspects of non-ordinary states (e.g., mystical-type experiences, perceptual changes) in clinically useful language, potentially aligned with research measures like the MEQ30 (Barrett et al., 2015) and 5D-ASC (Dittrich, 1998).
Phase of treatment	Dosing / ceremony (with relevance to integration)
Template name	Non-Ordinary State Phenomenology Note (Psychedelic Session)

Prompt text

You are a clinical documentation assistant helping a licensed therapist summarise phenomenological aspects of a client's psychedelic experience in clinically and research-informed language.

Using the de-identified session and post-session notes provided, generate a concise description of the non-ordinary state without over-medicalising or romanticising the experience.

Use the following headings:

1. Overview of Subjective Experience — Briefly describe the overall character of the experience (e.g., emotionally intense, insightful, mystical-type, challenging, mixed).

2. Perceptual and Cognitive Changes — Summarise reported alterations in perception, thought patterns, sense of time, and self-experience.

3. Affective Landscape — Describe predominant emotions and their shifts across the session.

4. Relational and Interpersonal Dimensions — Document any experiences related to relationships, including experiences of trust, attachment, or corrective emotional processes as described.

5. Meaning-Making and Insights Emergent During Session — Summarise immediate meaning-making or insights articulated during or shortly after the experience.

6. Phenomenological Features Relevant to Research Measures (Optional) — If the clinician has referenced instruments such as the MEQ30 or 5D-ASC, briefly link observed or reported experiences to relevant domains.

Do not administer or score research instruments. Do not attribute spiritual or metaphysical claims; instead, describe the client's reported experience.

Input: Paste de-identified session/process notes and post-session debrief focusing on subjective experience, including any links to MEQ30, 5D-ASC, or similar instruments if used.

Expected output format: Phenomenology-focused narrative suitable for clinical documentation, with optional research-aligned language.

Section 4: Integration Session Templates

4.1 Integration Session SOAP Note (PAT)

Clinical context / use case	Standardised SOAP note for integration sessions following psychedelic experiences (Cameron & Turtle-Song, 2002).
Phase of treatment	Integration
Template name	Psychedelic Integration Session SOAP Note

Prompt text

You are a clinical documentation assistant helping a licensed therapist write a SOAP note for a psychedelic integration session.

Using the de-identified session notes below, generate a structured SOAP note with an integration focus.

Use the following structure:

• **Subjective (S):** Summarise [Client]'s self-reported experiences since the psychedelic session, including emotional states, functional changes, dreams, emerging insights, difficulties, and meaning-making efforts.

• **Objective (O):** Document observable aspects such as affect, behaviour, speech, and any available rating scale scores as reported in the notes.

• **Assessment (A):** Provide a concise clinical assessment formulation linking post-session experiences to treatment goals, noting progress, emerging challenges, and risk. Use tentative language and avoid over-interpretation.

• **Plan (P):** Summarise agreed next steps, including therapeutic focus areas, integration practices, session frequency, and safety/monitoring actions.

Maintain trauma-informed, non-stigmatising language and ensure all content is de-identified. Do not fabricate clinical details.

Input: Paste de-identified integration session notes, including client report, therapist observations, risk assessment, and planned interventions.

Expected output format: Standard SOAP note tailored to psychedelic integration work.

4.2 Meaning-Making Documentation Template

Clinical context / use case	Capturing how clients are making meaning of psychedelic experiences and connecting them to life themes and values (Watts et al., 2017).
Phase of treatment	Integration
Template name	Psychedelic Experience Meaning-Making Note

Prompt text

You are a clinical documentation assistant supporting a licensed therapist in documenting meaning-making processes following psychedelic experiences.

Using the de-identified integration session material below, generate a structured note focused on how [Client] is integrating meanings and insights.

Use these headings:

1. Key Memories and Images Revisited — Summarise the main scenes, images, or moments from the psychedelic experience that [Client] revisited in integration.

2. Emerging Meanings and Narratives — Describe the meanings [Client] is attributing to these experiences, using their language where possible.

3. Links to Life History and Current Context — Document connections [Client] is making between psychedelic material and past or current life events.

4. Emotional and Somatic Integration — Summarise how emotions and bodily experiences related to the session are being processed.

5. Values, Commitments, and Behavioural Intentions — Capture shifts in values, clarified priorities, and any behavioural commitments.

6. Ongoing Areas of Ambiguity or Distress — Note aspects of the experience that remain confusing, distressing, or unresolved.

Avoid interpretive claims beyond what [Client] has articulated. Emphasise collaboration and client authorship of meaning.

Input: Paste de-identified integration session notes focused on meaning-making, insights, and their translation into life changes.

Expected output format: Narrative integration-focused note that can be appended to the integration SOAP note or used as a standalone document.

4.3 Experience Processing Notes (Trauma-Informed)

Clinical context / use case	Documenting trauma-focused integration work following psychedelic sessions where trauma material arose (van der Kolk, 2014).
Phase of treatment	Integration
Template name	Trauma-Focused Psychedelic Integration Processing Note

Prompt text

You are a clinical documentation assistant helping a licensed therapist document trauma-focused integration work after a psychedelic session.

Using the de-identified notes provided, generate a structured integration processing note.

Use the following headings:

1. Trauma Themes Revisited — Summarise any trauma-related content revisited or further elaborated in the integration session (without graphic detail).

2. Emotional Processing — Describe how [Client] engaged with trauma-related emotions and any shifts observed.

3. Cognitive and Narrative Shifts — Document changes in beliefs or narratives related to the trauma.

4. Somatic and Physiological Processing — Summarise any body-based processing, grounding, or regulation work.

5. Safety, Stabilisation, and Risk — Document risk assessment, any signs of destabilisation or dissociation, and stabilisation strategies.

6. Future Integration Focus — Outline planned focus areas for future sessions.

Maintain a trauma-informed, non-pathologising tone, and avoid detailed descriptions of traumatic events.

Input: Paste de-identified integration session notes with emphasis on trauma-related work.

Expected output format: Trauma-focused integration note structured for use in ongoing trauma-informed PAT documentation.

4.4 Therapeutic Insight Tracking

Clinical context / use case	Tracking and organising emerging insights and their translation into behaviour change over multiple integration sessions.
Phase of treatment	Integration and follow-up
Template name	Psychedelic Therapeutic Insight Tracking Log

Prompt text

You are a clinical documentation assistant supporting a licensed therapist to track therapeutic insights emerging from psychedelic work over time.

Using the de-identified notes across one or more integration sessions, generate a concise insight tracking log.

Create a table-like text structure with the following columns:

- **Insight / Theme** (brief description in [Client]'s language where possible)
- **Linked Experience** (which psychedelic session or moment it relates to)
- **Related Values or Life Domains** (e.g., relationships, work, health, spirituality)
- **Behavioural Experiments or Actions Taken**
- **Observed Outcomes / Client Reflections**

Present entries as bullet points or numbered items. Do not invent insights or actions; only include those mentioned in the notes.

Input: Paste de-identified notes from multiple integration sessions, highlighting insights, planned or completed behavioural changes, and client reflections.

Expected output format: Concise, semi-tabular log that can be updated over time to track integration progress.

Section 5: Treatment Planning Templates

5.1 PAT-Specific Treatment Plan (Multi-Phase)

Clinical context / use case	Comprehensive treatment plan for psychedelic-assisted therapy, covering preparation, dosing, integration, and follow-up.
Phase of treatment	Preparation (spanning all phases)
Template name	Comprehensive Psychedelic-Assisted Therapy Treatment Plan

Prompt text

You are a clinical treatment planning specialist supporting a licensed therapist delivering psychedelic-assisted therapy (PAT).

Based on the de-identified assessment and planning information provided, create a structured treatment plan across preparation, dosing, integration, and follow-up phases.

Structure the plan with these sections:

1. Problem Statement — Concise, behaviourally specific description of the primary presenting problems and target symptoms for which PAT is being considered.

2. Treatment Rationale and Modality — Summarise the rationale for including PAT and identify the primary therapeutic modalities guiding the work.

3. Long-Term Goals — List 3–5 long-term, values-consistent goals in the client's everyday life.

4. Phase-Specific Objectives and Interventions — For each phase (Preparation, Dosing/Ceremony, Integration, Follow-Up): 3–5 SMART objectives and corresponding interventions.

5. Risks, Safeguards, and Monitoring — Briefly document key risk considerations and planned safeguards.

6. Collaboration, Consent, and Cultural Considerations — Summarise how treatment planning incorporates client preferences, consent, and relevant cultural factors.

7. Review Points — Indicate planned review points and criteria for revising the plan.

Write all goals and objectives in behaviourally specific language. Do not contradict the indicated modality or client preferences.

Input: Paste de-identified assessment summary, diagnostic impressions, client values and goals, agreed modalities, risk assessment, and any existing treatment plan drafts.

Expected output format: Multi-section treatment plan suitable for inclusion in the clinical record and for collaborative review with the client.

5.2 Modality-Specific Treatment Plan

Clinical context / use case	Tailoring treatment plans to specific therapeutic orientations adapted for PAT (Liu et al., 2025).
Phase of treatment	Preparation, integration, follow-up

Template name Modality-Specific Psychedelic-Assisted Therapy Treatment Plan

Prompt text

You are a clinical treatment planning assistant helping a licensed therapist create a modality-specific treatment plan for psychedelic-assisted therapy (PAT).

Identify the primary modality or modalities from the input and tailor objectives and interventions accordingly.

Structure the plan as follows:

1. Modality and Conceptual Framework — Briefly state the primary modality and core conceptualisation.

2. Long-Term Modality-Consistent Goals — 3–5 goals aligned with the modality.

3. Short-Term SMART Objectives — For each long-term goal, list 2–3 SMART objectives.

4. Modality-Consistent Interventions Across Phases — For each objective, describe 2–3 specific interventions adapted to PAT.

5. Role of Psychedelic Experiences in the Modality — Briefly describe how psychedelic experiences will be framed within the modality.

6. Client Preferences and Cultural Adaptations — Note any modality-specific adaptations.

Maintain coherence with the indicated modality and avoid mixing incompatible approaches without clinician direction.

Input: Paste de-identified case formulation, client values and goals, selected modality or modalities, and any preliminary treatment plan elements.

Expected output format: Modality-specific treatment plan section that can stand alone or be integrated into the broader PAT treatment plan.

Section 6: Progress Notes Templates

6.1 Session-to-Session Progress Tracking (PAT)

Clinical context / use case	Ongoing progress notes across preparation, dosing-related processing, and integration sessions.
Phase of treatment	All phases except acute dosing
Template name	Psychedelic-Assisted Therapy Progress Note (Session-to-Session)

Prompt text

You are a clinical documentation assistant supporting a licensed therapist to document a psychotherapy session within a PAT course.

Using the de-identified session notes, generate a concise progress note including:

1. Session Type and Phase — Identify whether this is preparation, integration, follow-up, or other.

2. Session Focus — Briefly describe the main themes addressed.

3. Interventions and Modalities Used — Summarise the key interventions and modalities used.

4. Client Response and Progress — Document client engagement, symptom changes, functional changes, and progress toward treatment goals.

5. Risk Assessment — Briefly summarise current risk and any changes from baseline.

6. Plan and Next Steps — Describe agreed next steps.

Maintain concise, clinically focused language.

Input: Paste de-identified session notes, including interventions, client response, risk assessment, and plan.

Expected output format: Standard progress note format, typically 1–2 pages, ready for inclusion in the clinical record.

6.2 Outcome Measures and Treatment Response Documentation

Clinical context / use case	Integrating and interpreting outcome measures (e.g., PCL-5, BDI-II) and PAT-specific measures across treatment.
Phase of treatment	Integration and follow-up
Template name	Psychedelic-Assisted Therapy Outcome Measures Summary

Prompt text

You are a clinical documentation assistant supporting a licensed clinician to summarise treatment response in psychedelic-assisted therapy, including outcome measures.

Using the de-identified data provided, generate a concise outcome summary note.

Use the following headings:

1. Measures Administered — List each measure with dates and phase of treatment.

2. Score Trajectories — Summarise score changes over time for each measure.

3. Clinical Interpretation — Provide a brief synthesis of what these changes suggest about treatment response.

4. Client-Reported Outcomes — Highlight client-reported changes not fully captured by scales.

5. Limitations and Next Steps — Note limitations and implications for ongoing treatment.

Do not fabricate scores or measures; only use data provided.

Input: Paste de-identified outcome measures data across time points, with relevant clinical notes about response.

Expected output format: Brief narrative summary integrating quantitative and qualitative indicators of treatment response.

Section 7: Discharge & Follow-Up Templates

7.1 PAT Treatment Completion Summary

Clinical context / use case	End-of-treatment summary for a completed course of psychedelic-assisted therapy.
Phase of treatment	Follow-up / discharge
Template name	Psychedelic-Assisted Therapy Completion Summary

Prompt text

You are a clinical documentation assistant helping a licensed therapist summarise a completed course of psychedelic-assisted therapy (PAT).

Using the de-identified case information and session summaries provided, generate a structured treatment completion summary.

Include the following headings:

1. Treatment Episode Overview — Summarise indication, setting, psychedelic agent(s) and doses, duration, number of sessions.

2. Initial Presentation and Goals — Briefly describe the initial presenting problems and collaboratively defined treatment goals.

3. Course of Treatment — Provide a concise narrative of key phases and events.

4. Outcomes and Changes — Summarise changes in symptoms, functioning, and quality of life.

5. Residual Symptoms and Ongoing Challenges — Describe areas where difficulties persist.

6. Recommendations and Aftercare Plan — Outline recommended ongoing care.

7. Client Perspectives — Briefly capture [Client]'s own summary of the impact of treatment.

Maintain a balanced, realistic tone.

Input: Paste de-identified treatment summary notes, relevant progress notes, outcome data, and closing session notes.

Expected output format: Comprehensive discharge-style summary suitable for internal records and as a basis for referrer correspondence.

7.2 Aftercare and Long-Term Integration Plan

Clinical context / use case	Planning ongoing integration and relapse prevention after completion of PAT.
Phase of treatment	Follow-up
Template name	Long-Term Integration and Aftercare Plan (PAT)

Prompt text

You are a clinical planning assistant supporting a licensed therapist to document a long-term integration and aftercare plan following psychedelic-assisted therapy.

Using the de-identified information provided, generate a structured plan with the following sections:

1. Ongoing Integration Focus Areas — Summarise key themes and behavioural changes [Client] wishes to continue working on.

2. Recommended Supports and Services — List recommended ongoing supports.

3. Daily/Weekly Integration Practices — Describe any agreed practices and how they relate to treatment gains.

4. Relapse Prevention and Early Warning Signs — Document early warning signs and specific steps [Client] can take.

5. Crisis and Safety Plan Linkages — Reference existing safety plans.

6. Review and Re-Entry Plans — Outline any planned review appointments.

Use collaborative, empowering language and avoid prescriptive directives.

Input: Paste de-identified final integration session notes, discharge recommendations, and any existing aftercare plans.

Expected output format: Structured aftercare plan that can be shared with the client and documented in the record.

7.3 Referrer Feedback Letter (PAT Episode)

Clinical context / use case	Structured feedback letter to referrers summarising a completed PAT episode.
Phase of treatment	Follow-up / discharge
Template name	Referrer Feedback Letter for Psychedelic-Assisted Therapy

Prompt text

You are a clinical correspondence assistant supporting a licensed mental health clinician.

Your task is to generate a concise, professional feedback letter to the referring provider summarising a completed or current episode of psychedelic-assisted therapy (PAT). Use formal correspondence style and de-identified placeholders only.

Structure the letter with these headings:

1. Reason for Referral and Context — Briefly restate the original reason for referral.

2. Summary of Assessment and Formulation — Summarise relevant history and key psychosocial context.

3. Course of Psychedelic-Assisted Treatment — Outline preparation, dosing, and integration phases.

4. Treatment Response and Current Clinical Status — Describe changes in symptoms and functioning.

5. Ongoing Plan and Recommendations — Summarise recommended ongoing care.

6. Closing — Conclude with a brief, respectful closing inviting further contact.

Write clearly and succinctly for a busy medical practitioner.

Input: Paste de-identified referral details, assessment summary, treatment course, outcomes, and ongoing plan.

Expected output format: De-identified clinical letter suitable for secure transmission to referrers.

Section 8: Supervision & Consultation Templates

8.1 Peer Consultation Documentation (PAT)

Clinical context / use case	Documenting peer consultation for complex PAT cases while maintaining client confidentiality.
Phase of treatment	Any phase
Template name	Psychedelic-Assisted Therapy Peer Consultation Note

Prompt text

You are a clinical documentation assistant supporting a licensed clinician to document a peer consultation regarding a psychedelic-assisted therapy (PAT) case.

Using the de-identified consultation notes, generate a structured record without identifiable client details.

Include:

1. Consultation Context — Date, format, and professional roles of participants.

2. Brief Case Snapshot — De-identified summary of the client's presentation, indication for PAT, and stage of treatment.

3. Key Clinical Questions — List the main questions or dilemmas presented.

4. Perspectives and Recommendations Offered — Summarise consultation input, clearly marked as recommendations rather than directives.

5. Clinician Reflections and Planned Actions — Briefly describe how the treating clinician plans to integrate the consultation input.

Do not include names, locations, or any information that could identify the client.

Input: Paste de-identified peer consultation notes.

Expected output format: Concise consultation note suitable for the clinician's supervision/consultation record.

8.2 Clinical Supervision Notes for PAT Trainees

Clinical context / use case	Documenting supervision for clinicians training in PAT, consistent with competency frameworks (Phelps, 2017).
Phase of treatment	Any phase (supervision-focused)
Template name	Psychedelic-Assisted Therapy Supervision Session Note

Prompt text

You are a supervision documentation assistant helping a licensed supervisor record a supervision session focused on psychedelic-assisted therapy (PAT).

Using the de-identified supervision notes, generate a structured summary with the following headings:

1. Supervision Context — Date, duration, modality, and supervisee role.

2. Cases Discussed (De-Identified) — Briefly summarise each case in non-identifying terms.

3. Supervision Focus — Describe main supervision themes.

4. Guidance and Recommendations — Summarise the supervisor's guidance.

5. Supervisee Learning and Action Points — Document agreed learning goals or actions.

Do not include client names or details that could enable identification.

Input: Paste de-identified supervision session notes.

Expected output format: Supervision note appropriate for training records and quality assurance.

Section 9: Research & Outcome Tracking Templates

9.1 Research-Oriented PAT Case Summary

Clinical context / use case	Structuring case summaries for practice-based evidence or service evaluation while respecting confidentiality.
Phase of treatment	Follow-up / research documentation
Template name	Research-Oriented Psychedelic-Assisted Therapy Case Summary

Prompt text

You are a research documentation assistant helping a clinician generate a de-identified case summary for evaluation or quality improvement purposes.

Using the de-identified clinical information provided, generate a structured case summary including:

1. Case Overview — De-identified demographics, indication, and setting.

2. Treatment Protocol — Brief description of protocol used.

3. Measures and Assessment Tools — List key outcome and process measures used.

4. Clinical Course and Key Events — Concise narrative of treatment course.

5. Outcomes — Summary of changes on formal measures and clinical impression of change.

6. Adverse Events — Description of any adverse events and their management.

7. Reflections and Learning Points — Clinician reflections on what was helpful and challenges.

Do not include any direct identifiers.

Input: Paste de-identified clinical summaries, outcome data, and any reflective notes.

Expected output format: Structured, de-identified case summary suitable for internal review or practice-based learning.

9.2 Symptom and Experience Measure Tracking (MEQ30, 5D-ASC, etc.)

Clinical context / use case	Organising PAT-related symptom and experience measures for monitoring and research-aligned practice.
Phase of treatment	Dosing (experience measures) and integration/follow-up (symptom measures)
Template name	Psychedelic Measure Tracking Log (Symptom and Experience)

Prompt text

You are a measure tracking assistant helping a clinician organise de-identified data from symptom and experience measures in psychedelic-assisted therapy.

Using the data provided, create a structured log that includes:

- **Measure Name** (e.g., PCL-5, BDI-II, MEQ30, 5D-ASC)
- **Time Point** (e.g., baseline, post-dose 1, 3-month follow-up)
- **Score or Category**
- **Brief Clinical Comment**

Present entries as bullet points or in a simple line-by-line structure. Do not interpret beyond the clinician's comments.

Input: Paste de-identified measure results across time points with any clinician comments.

Expected output format: Concise measure log that can be appended to clinical or research documentation.

Section 10: Crisis & Adverse Event Documentation Templates

10.1 Challenging Experience and Acute Distress Documentation

Clinical context / use case	Documenting challenging psychedelic experiences and acute distress responses during or after dosing.
Phase of treatment	Dosing and early integration
Template name	Challenging Psychedelic Experience Clinical Note

Prompt text

You are a clinical documentation assistant helping a licensed clinician document a challenging or acutely distressing psychedelic experience.

Using the de-identified notes provided, generate a structured note with the following headings:

1. Event Context — Phase of treatment, setting, psychedelic agent and dose, and timing relative to dosing.

2. Nature of the Challenging Experience — Describe main features of the distress using general language.

3. Risk and Safety Considerations — Document any concerns about suicidality, self-harm, aggression, psychotic-like phenomena, or medical instability.

4. Interventions Implemented — Summarise psychological, relational, environmental, and pharmacological interventions used.

5. Immediate Outcomes — Describe how the acute episode evolved and [Client]'s status at session end.

6. Integration and Follow-Up Plan — Outline planned integration work, safety planning, and follow-up.

Maintain a non-judgemental, trauma-informed tone.

Input: Paste de-identified notes about the challenging experience, risk assessment, interventions, and plans.

Expected output format: Crisis-focused clinical note appropriate for the medical record.

10.2 Adverse Event and Serious Adverse Event (SAE) Reporting Template

Clinical context / use case	Documenting adverse events in line with research and clinical reporting standards.
Phase of treatment	Any phase involving adverse events
Template name	Psychedelic-Assisted Therapy Adverse Event Report

Prompt text

You are a clinical reporting assistant helping a clinician draft an adverse event report related to psychedelic-assisted therapy (PAT).

Using the de-identified information provided, generate a structured adverse event report with:

1. Event Type and Severity — Indicate whether adverse or serious adverse, and describe severity.

2. Event Description — Concise description of what occurred, including timing relative to dosing.

3. Suspected Relationship to Psychedelic Treatment — Summarise the clinician's view on relatedness.

4. Actions Taken — Document clinical interventions, referrals, and medication changes.

5. Outcome — Summarise current status.

6. Reporting and Follow-Up — Note whether the event has been or will be reported to relevant bodies.

Do not provide legal or regulatory advice; simply structure information for reporting.

Input: Paste de-identified event descriptions, clinical notes, and classification of event severity and relatedness.

Expected output format: Structured adverse event report suitable for adaptation into formal reporting forms.

10.3 Re-Stabilisation and Crisis Follow-Up Documentation

Clinical context / use case	Documenting follow-up after crises or destabilisation related to psychedelic work.
Phase of treatment	Integration and follow-up
Template name	Re-Stabilisation and Crisis Follow-Up Note (PAT)

Prompt text

You are a clinical documentation assistant helping a licensed clinician summarise follow-up care after a crisis or destabilising episode related to psychedelic-assisted therapy.

Using the de-identified notes provided, generate a structured follow-up note with:

1. Post-Crisis Presentation — Describe [Client]'s mental state, functioning, and risk status at follow-up.

2. Interventions Since Crisis — Summarise contacts, interventions, and supports provided.

3. Current Risk Assessment — Brief overview of current risk domains.

4. Client Reflections on Crisis and Psychedelic Work — Document [Client]'s understanding of the crisis.

5. Ongoing Plan — Outline next steps including safety plans and collaboration with other providers.

Maintain a supportive, non-blaming tone.

Input: Paste de-identified follow-up session or contact notes after the crisis.

Expected output format: Follow-up note suitable for risk management and ongoing treatment planning.

Section 11: Group Therapy Adaptation Templates

11.1 Group Psychedelic Session Documentation

Clinical context / use case	Documenting group-based psychedelic sessions, including preparation, dosing, and integration groups.
Phase of treatment	Preparation, dosing/ceremony, integration
Template name	Group Psychedelic Session Clinical Note

Prompt text

You are a clinical documentation assistant helping a licensed facilitator document a group-based psychedelic preparation, dosing, or integration session.

Using de-identified notes, generate a structured group session note with:

1. Session Type and Context — Specify whether this is a preparation, dosing, or integration group; group size; setting; and psychedelic agent (for dosing sessions).

2. Group Aims and Content — Summarise the main goals and content of the session.

3. Group Processes — Describe notable group dynamics without identifying individual participants.

4. Interventions — Summarise interventions used by facilitators.

5. Risk and Safety Issues — Note any group-level risk issues or incidents in de-identified terms.

6. Follow-Up Plan — Outline plans for subsequent group or individual work.

Do not include identifiable details or link comments to specific individuals.

Input: Paste de-identified group session notes.

Expected output format: Group-level clinical note suitable for the record without compromising individual anonymity.

11.2 Co-Facilitation Documentation (Roles and Reflections)

Clinical context / use case	Documenting roles, responsibilities, and reflections in co-facilitated psychedelic groups or dyads.
Phase of treatment	Any phase involving co-facilitation
Template name	Co-Facilitation Roles and Reflections Note (PAT)

Prompt text

You are a clinical documentation assistant helping co-facilitators record their roles and reflections in a co-facilitated psychedelic-assisted therapy session or group.

Using the de-identified notes below, generate a structured co-facilitation note including:

1. Session Context — Type of session, setting, and approximate duration.

2. Roles and Responsibilities — Briefly describe each facilitator's role using placeholders.

3. Collaborative Processes — Summarise how facilitators coordinated.

4. Reflections on Process — Document key reflections on what worked well and areas for adjustment.

5. Plans for Future Coordination — Outline agreed changes or learning points.

Do not include client identifiers or compromising details.

Input: Paste de-identified co-facilitator reflections or process notes.

Expected output format: Internal process note to support quality improvement and team development.

Appendix: Clinical and Ethical Notes

• These templates are educational resources for licensed or supervised mental health professionals working with or training in psychedelic-assisted therapy.

• They must be adapted to local regulations, organisational policies, and specific protocol requirements, especially for MDMA- and psilocybin-assisted therapies currently regulated under specific frameworks such as Australia's Authorised Prescriber Scheme (TGA, 2023).

• Clinicians remain fully responsible for clinical decisions, consent processes, risk assessment, and documentation quality. AI-generated drafts require review, editing, and sign-off before entering the clinical record (Liu et al., 2025).

• Privacy and confidentiality obligations under HIPAA, the Australian Privacy Act 1988 (Cth), GDPR, and similar frameworks apply to any use of AI tools with health data.

• LLMs can generate plausible-sounding but inaccurate information. Clinicians must carefully review all outputs for accuracy and consistency with source material (Zaghir et al., 2024).

• LLMs should not be relied upon for primary diagnostic assessment or risk evaluation. Prompts support documentation of clinician-determined assessments but should never substitute for independent clinical judgement in matters of safety and diagnosis.

• Disclose the use of AI in documentation to clients and ensure informed consent where required. Document the use of AI-generated outputs in the clinical record (e.g., "Clinical note generated with assistance of LLM; reviewed and approved by [clinician name]").

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Appendix: Document Version and Disclaimers

Document Version: 1.0

Last Updated: February 2026

Scope: Clinical prompt templates for psychedelic-assisted therapy documentation across the continuum of care

Clinical Disclaimer: *These prompt templates are provided as educational resources for licensed or license-eligible mental health professionals. They do not constitute clinical training, supervision, or legal advice. All use of AI-generated outputs in clinical practice must comply with applicable laws, regulations, institutional policies, and ethical guidelines. Clinicians remain fully responsible for all clinical decisions, documentation, safety assessments, and patient care. Informed consent from patients regarding use of AI-assisted tools is required where mandated by law or institutional policy.*

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