Mental Health Treatment Plan
Item No: 2710 or 2702

Step 1 - Patient Assessment

Patient Name:				**Outcome Tool** K10	**Result**
DOB:		**Gender:**		**Date:**	
Referring GP Details:	Name: Practice: Provider No:				

Problem/Diagnosis - the GP must document a mental disorder in the Plan	
Number 1:	
Number 2:	
Number 3:	

Medications

Past History

Mental Health History/Treatment

Has the person ever received specialist mental health care?

Other Relevant Information:
Language spoken at home:

How well does the person speak English:

Family History

Social History

Does the person live alone:

Highest education level completed:

Other Relevant Information:

Alcohol:

Smoking:

Personal History/Lifestyle Issues (eg childhood, substance abuse, relationship history, coping with previous stressors)

Relevant Physical and Mental Examination

Allergies

Investigations

Mental Status Examination	
Appearance and General Behaviour ❑ Normal ❑ Other:	**Mood** (Depressed/Labile) ❑ Normal ❑ Other:
Thinking (Content/Rate/Disturbances) ❑ Normal ❑ Other:	**Affect** (Flat/blunted) ❑ Normal ❑ Other:
Perception (Hallucinations etc.) ❑ Normal ❑ Other:	**Sleep** (Initial Insomnia/Early Morning Wakening) ❑ Normal ❑ Other:
Cognition (Level of Consciousness/Delirium/Intelligence) ❑ Normal ❑ Other:	**Appetite** (Disturbed Eating Patterns) ❑ Normal ❑ Other:
Attention/Concentration ❑ Normal ❑ Other:	**Motivation/Energy** ❑ Normal ❑ Other:
Memory (Short and Long Term) ❑ Normal ❑ Other:	**Judgement** (Ability to make rational decisions) ❑ Normal ❑ Other:
Insight ❑ Normal ❑ Other:	**Anxiety Symptoms** (Physical & Emotional) ❑ Normal ❑ Other:
Orientation (Time/Place/Person) ❑ Normal ❑ Other:	**Speech** (Volume/Rate/Content) ❑ Normal ❑ Other:

Risk Assessment			
Suicidal Ideation		**Suicidal Intent**	
Current Plan		**Risk to Others**	

Key Family/Support Contact	

FORMULATION
Main Problems/Diagnosis (Risk/protective factors)

Other Mental Health Professionals Involved in Patient Care **Name/Profession:**	**Contact Number**

Patient Education Given	**Yes No**

Step 2 - Mental Health Treatment Plan

Problem/Diagnosis	**Goal** (eg reduce symptoms, improve functioning)	**Action/Task** (eg psychological or pharmacological treatment, referral, engagement of family and other supports)
Number 1:		
Number 2:		
Number 3:		
<<Principal problem/diagnosis 3>>		

Emergency Care/Relapse Prevention	

Patient Education given:	Yes No	**Key family contact/support details/phone:**
Copy of MH Plan given to patient:	Yes No	

Initial Action Plan - to be considered for: Taking into account the issues that you and the patient have identified, summarise the initial action suggested (Highlight appropriate tick box and type an "x")

- ❑ Diagnostic assessment
- ❑ Psycho-education
- ❑ Interpersonal Therapy
- ❑ Cognitive Behavioural Therapy (CBT)
  - ❑ Behavioural interventions
  - ❑ Relaxation strategies
  - ❑ Cognitive interventions (specify)
  - ❑ Skills training
  - ❑ Other CBT interventions (specify) :
- ❑ Other (specify):

Joint Session Request (OPTIONAL): Tick either first or last session AND either GP Practice or Res.Aged Care Fac.

First ❑ **OR** ❑ Last session **AT** ❑ GP Practice **OR** ❑ Residential Aged Care Facility

Review Date: (Add a Recall in MD for 1-6 months after the **Plan** date)	

Record of Patient Consent

I, _____, (**patient** name - please print clearly)

Consent to this Care Plan to proceed and I agree to information about my mental health being recorded in my medical file and being shared between the GP and the counsellor(s) to whom I am referred, to assist in the management of my health care.

_____ _____

Signature (patient): **Date:**

I (GP) have discussed the proposed referral(s) with the patient and am satisfied that the patient understands the proposed uses and disclosures and has provided their informed consent to these.

_____ _____ _____

GP Signature **GP Name** **Date**

Referring GP Details:	Name: Practice: Provider No:

Mental Health Review Item No: 2712 (Review)

GP Mental Health Treatment Plan Review	Date: (4 weeks to 6 months from date of Plan)	

Patient Name:	<<Patient Demographics:Full Details>>			Outcome Tool K10	Result
DOB:	<<Patient Demographics:DOB>>	Gender:	<<Patient Demographics:Sex>>	Date:	
GP Name:	<<Doctor:Name>>				

Problem/Diagnosis	Goal	Progress on Actions and Tasks
Number 1:		
<<Principal problem/diagnosis 1>>		
Number 2:		
<<Principal problem/diagnosis 2>>		
Number 3:		
<<Principal problem/diagnosis 3>>		

Follow-up Relapse Prevention Plan

Re-referral section if further Allied Health Practitioner sessions required: (Maximum of 6 further sessions)

Record of Patient Consent

I, _____, (**patient** name - please print clearly)

Agree to information about my mental health and well being to be shared between the GP and the counsellor(s) to whom I am referred, to assist in the management of my health care.

_____ _____

Signature (patient): **Date:**

I (GP) have discussed the proposed referral(s) with the patient and am satisfied that the patient understands the proposed uses and disclosures and has provided their informed consent to these.

_____ _____ _____

GP Signature **GP Name** **Date**

Referring GP Details:	Name: <<Doctor:Name>> Practice: <<Practice:Name>> Provider No: <<Doctor:Provider Number>>