

GP Mental Health Treatment Plan Item No. 2710 (Assessment and Plan)

Part 1. Patient Assessment

Patient name		Gender	
Address		DOB	
Contact Details	Home Phone:	Medicare Number	
	Mobile:		
GP		Practice Details	
GP Provider No.			
Date			

Presenting Problem (Patient's current mental health issues; most recent psychiatric history including hospitalizations, treatments):

Other Information

- * Does the person live alone?
- * Language spoken at home?
- * Highest education level achieved?
- * Has patient received specialist mental health care?

Co-morbidities: physical; alcohol and/or drug use:

Patient History (record relevant biological, psychological and social history, including family history of mental health issues, relevant substance use issues, physical health issues):

Medications: current

Allergies:

Mental Health Examination	
General Appearance <input type="checkbox"/> Normal <input type="checkbox"/> Other:	Mood (Depressed/Labile) <input type="checkbox"/> Normal <input type="checkbox"/> Other:
Behaviour <input type="checkbox"/> Normal <input type="checkbox"/> Other:	Affect (Flat/blunted) <input type="checkbox"/> Normal <input type="checkbox"/> Other:
Perception (Hallucinations etc.) <input type="checkbox"/> Normal <input type="checkbox"/> Other:	Speech (Volume/Rate/Quality) <input type="checkbox"/> Normal <input type="checkbox"/> Other:
Cognition (Level of Consciousness/Delirium/Intelligence) <input type="checkbox"/> Normal <input type="checkbox"/> Other:	Judgment/Insight (Ability to make rational decisions) <input type="checkbox"/> Normal <input type="checkbox"/> Other:
Intelligence <input type="checkbox"/> Normal <input type="checkbox"/> Other:	Thought Form/Flow <input type="checkbox"/> Normal <input type="checkbox"/> Other:
Thought Content (incl. delusions, phobias, obsessions, fears) <input type="checkbox"/> Normal <input type="checkbox"/> Other:	

RISK ASSESSMENT: Circle as appropriate; if patient responds YES, provide details	
Suicidal Ideation/thoughts?	No Yes (details) -
Suicidal intent?	No Yes (details) -
Access to means?	No Yes (details) -
Current Plan?	No Yes (details) -
Risk to others?	No Yes (details) -
Protective Factors (family/friends/community/social supports; insight and understanding; positive coping behaviours; active help-seeking):	
If HIGH LEVEL OF RISK INDICATED, document action taken:	

Outcome Measurement Tool: <i>(if clinically appropriate):</i>	
FORMULATION	
Main Problems/Diagnosis:	
Other Mental Health Professionals Involved in Patient Care	Contact Number
Name/Profession:	

2. Patient Treatment Plan

Patient name	
Gender	
DOB	
Date	

Patient needs/main concern	Goals <i>What do what to achieve? E.g. reduce symptoms, improve functioning as agreed with the patient</i>	Action/task <i>How are you going to achieve this? Who is going to do what? E.g. pharmacological &/or psychological treatment referral, engagement of family and other supports.</i>
Concern/issue 1	Goal 1	Action 1
Concern/issue 2	Goal 2	Action 2
Concern/issue 3	Goal 3	Action 3

Initial Action Plan - to be considered for: *Taking into account the issues that you and the patient have identified above highlight appropriate tick box below:*

Diagnostic assessment
 Psycho-education
 Interpersonal Therapy

Cognitive Behavioural Therapy (CBT)

Behavioural interventions
 Relaxation strategies
 Other CBT interventions (specify) :

Cognitive interventions
 Skills training

Other (specify):

Private Referral Options (please indicate) **send completed GPMHTP (2710) directly to nominated provider:**

Medicare - Better Access - Preferred Provider Name:

Peninsula headspace [young people aged 12-25years] Phone: 9769 6419 Fax: 9770 5688

Other: Provider name & Contact details:

PGPN Program Referrals

All PGPN Referrals - GP to forward completed GPMHTP (2710) to PGPN - Program Staff will contact provider to coordinate patient contact and initial appointment. **Fax 9708 8157** or contact **Ph: 9708 8019**

PGPN ATAPS Counselling Program - Preferred Provider Name:
Note: Patients must be Health Care Card Holders.

PGPN Mental Health Nurse Program- Preferred Provider Name:
Note: Specific intake and eligibility criteria - contact PGPN Project Officer for details

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

Emergency/Crisis Care Plan:

Key Family contact/support:

Relapse Prevention Plan:

Copy of MH plan given to patient: No Yes (circle as appropriate)
Psycho-education provided to patient: No Yes (circle as appropriate)

Patient Privacy and Consent issues discussed:

In making the referral your GP will exchange information about your health assessment, plan and progress with the allied health provider, and will provide the allied health provider with a copy of this assessment and plan. If the referral is to a PGPN Program, the plan will be forwarded to the GP Network first for activation. Some non-identifiable statistical information will be collected from this documentation for program evaluation and review purposes.

Record of Patient Consent

I, (patient name) 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)/mental health practitioners to whom I am being referred, to assist in the management of my health care. I understand the above Mental Health Care Plan and agree to the outlined goals/actions.

Patient signature	
GP signature	