Mental Health Treatment Plan

Patient Assessment

Patient information

Name:				
Date of birth:	Age:	Sex:	Male	Female
Address:				
Phone (home):	Phone (mobile):			
Phone (work):	Medicare number:			
Emergency contact:				
Aboriginal or Torres Strait Islander:				

General practitioner details

GP name:	Practice name:	
Medicare provider number:	Phone:	Fax:
GP address:		Post code:

Assessment details

Date of assessment, plan and referral:
Other care plan (e.g. GPMP/TCA):
AHP or nurse currently involved in patient care:
Level of priority of consultation:

Risk assessment

Medications

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Allergies

What are the patient's current mental health issues?

☐ Anxiety	☐ GAD	☐ OCD	☐ Social phobia	
	☐ PTSD	☐ Panic disorder	☐ Agoraphobia	
☐ Mood disorder	☐ Depression	☐ Dysthymia		
☐ Perinatal (ante/post natal)	☐ Depression	☐ Anxiety (incl PTSD)	☐ Psychosis	
☐ Serious mental illness	☐ Schizophrenia	☐ Schizoaffective disorder	☐ Other	
☐ Personality disorder	☐ Borderline	☐ Antisocial	☐ Avoidant	☐ Dependent
☐ Other issues	Specify:			
☐ Substance use or misuse	Specify:			

History of presenting issues

When the problem first started, triggers, course of problem.

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History of presenting issues

Current mental state

Outcome tool

Relevant physical health problems

Relevant background issues

Previous trauma, abuse, sexual assault?

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Family history of mental illness?	
☐ Autism spectrum (specify):	☐ Intellectual disability
☐ Behavioral problems	☐ Learning difficulty
☐ ADHD/ADD	☐ Language difficulty
☐ Conduct disorder	☐ Other (specify):
Social history	
Income status:	Relationship status:
Higher education level achieved:	Living situation:

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Relevant Background Issues

Care plan

Patient needs/main issues	Goals	Treatments	Referrals	Review

Crisis relapse plan

Tick the boxes if you agree:

- ☐ Appropriate psychoeducation provided?
- ☐ Plan added to the patient's records?
- ☐ Copy (or parts) of the plan offered to other providers?

Completing the plan

In completing the mental health treatment plan, I have discussed with the patient: (tick relevant boxes)

- ☐ The assessment
- ☐ All aspects of the plan, including referrals to other providers
- ☐ The possibility of a case conference with other care providers
- ☐ Agreed date for review
- ☐ Offered a copy of the plan to the patient and/or their carer (if agreed by the patient)

Date plan completed:	Review date:

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Referral and patient consent

I,_____(GP name) am referring this patient for treatment. I have discussed the proposed referral with the patient and am satisfied that the patient understands the reason for the referral.

GP signature:	Date:

I,_____(patient name) declare that my GP has explained why I have been referred to the above service. I agree to information about my mental health and wellbeing, medical and social history being shared between my GP and the appropriate staff involved in the management of my health care. I understand that this may occur during a case conference.

If Grand Pacific Health (GPH) is to be the treatment provider, please send this completed Mental Health Treatment Plan to:

GPH via secure fax: 4226 6489

Please note: GPH does not provide a crisis service.

Patients with acute mental illness should be referred to:

Mental Health Helpline: 1800 011 511 (24 hours)