

TREATMENT PLAN

T: 1300 782 391 | F: 02 8072 6899

GP MENTAL HEALTH TREATMENT PLAN

PATIENT ASSESSMENT

PATIENT NAME:

DATE OF BIRTH:

PRESENTING ISSUE(S):

What are the patient's current mental health issues?

CURRENT SITUATION:

Predisposing factors, precipitating factors, stressors Symptom onset, duration, intensity, time course

PATIENT HISTORY:

Record relevant physical and mental health history

FAMILY HISTORY:

Mental Illness
History of suicide

SOCIAL SUPPORT:

Social history, family contact and support including living arrangements, occupation

TREATMENT PLAN

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GP MENTAL HEALTH TREATMENT PLAN (CONTINUED)

<p>MEDICATIONS:</p> <p>Current and past medications and any side effects</p>													
<p>ALLERGIES:</p>													
<p>MENTAL STATE EXAMINATION:</p> <p>Consider appearance, cognition, thought process, thought content, attention, memory, insight, behaviour, speech, mood and affect, perception, judgement, orientation</p>													
<p>RISK ASSESSMENT:</p> <p>Consider suicidal thoughts, ideation, self-harm and risk of harm to others</p>	<table border="0"> <tr> <td>Suicidal Thoughts:</td> <td>Yes</td> <td>No</td> <td>Suicidal Intent:</td> <td>Yes</td> <td>No</td> </tr> <tr> <td>Current Plan:</td> <td>Yes</td> <td>No</td> <td>Risk to Others:</td> <td>Yes</td> <td>No</td> </tr> </table> <p>If answer is 'yes' to plan, intent or risk to others, refer to Mental Health Access Line: 1800 011 511</p>	Suicidal Thoughts:	Yes	No	Suicidal Intent:	Yes	No	Current Plan:	Yes	No	Risk to Others:	Yes	No
Suicidal Thoughts:	Yes	No	Suicidal Intent:	Yes	No								
Current Plan:	Yes	No	Risk to Others:	Yes	No								
<p>OUTCOME TOOL:</p> <p>Tool used and results</p>													
<p>DIAGNOSIS:</p> <p>May be provisional</p>													
<p>ANY OTHER COMMENTS:</p>													

GP MENTAL HEALTH TREATMENT PLAN (CONTINUED)

PATIENT PLAN			
Patient Name:		Date of birth:	
PATIENT NEEDS / MAIN ISSUES	GOALS	TREATMENTS	REFERRALS
	Record the mental health goals agreed to by the patient and GP and any actions the patient will need to take	Treatments, actions and support services to achieve patient goals	Note: Referrals to be provided by GP, as required, in up to two groups of six sessions. The need for the second group of sessions to be reviewed after the initial six sessions.
CRISIS / RELAPSE	If required, note the arrangements for crisis intervention and/or relapse prevention		

GP MENTAL HEALTH TREATMENT PLAN (CONTINUED)

APPROPRIATE PSYCHO-EDUCATION PROVIDED		PLAN ADDED TO THE PATIENT'S RECORDS		COPY (OR PARTS) OF THE PLAN OFFERED TO OTHER PROVIDERS		
Yes	No	Yes	No	Yes	No	Not required
PATIENT PREFERRED PROVIDER: (SUBJECT TO AVAILABILITY AND MAY BE LEFT BLANK)						
1.						
2.						
COMPLETING THE PLAN						
On completion of the plan, the GP is to record that s/he has discussed with the patient:						
<ul style="list-style-type: none"> • The assessment; • All aspects of the plan and the agreed date for review; and • Offered a copy of the plan to the patient and/or their carer (if agreed by patient) 						
GP SIGNATURE						
DATE PLAN COMPLETED				REVIEW DATE (initial review 4 weeks to 6 months after completion of plan)		
REVIEW COMMENTS (Progress on actions and tasks)				OUTCOME TOOL RESULTS ON REVIEW		