Patient wellbeing assessment and recovery plan

Subjective, objective, assessment, plan (SOAP)

Notes: This form is designed for use with the following Medicare Benefits Schedule (MBS) items. Users should be familiar with the most recent item definitions and requirements.

MBS item number: 2700 2701 2715 2717

This document is **not** a referral letter. A referral letter must be sent to any additional providers involved in this Mental Health Treatment Plan.

Contact and demographic details

GP name

GP phone

GP practice name

GP fax

GP address

Provider number

Relationship:

This person has been my patient since / / and/or This person has been a patient at this practice since / /

Patient surname

Date of birth (dd/mm/yy)
/ /

Patient first name/s

Preferred name

Gender: Female Male Self-identified gender:

Patient address

Patient phone

Preferred number

Can leave message? Yes No

Alternative number

Can leave message? Yes No

Medicare number

Health Care Card number

Pensioner Concession Card number

ID-19

Carer/support person contact details

First contact Relationship

Phone number 1 Phone number 2

Has patient consented for this healthcare team to contact carer/support persons? Yes No

With the following restrictions

Second contact Relationship

Phone number 1 Phone number 2

Has patient consented for this healthcare team to contact carer/support persons? Yes No

With the following restrictions

Emergency contact person details

First contact Relationship

Phone number 1 Phone number 2

Has patient consented for this healthcare team to contact carer/support persons? Yes No

Second contact Relationship

Phone number 1 Phone number 2

Has patient consented for this healthcare team to contact carer/support persons? Yes No

Salient communication and cultural factors

Language spoken at home: English Other:

Interpreter required: No Yes, comments:

Country of birth: Australia Other:

Other communication factors

Other relevant cultural factors

S – 'Subjective'

Consider:*

- Reasons for presenting
- History of current episode
- Mental health history
- Salient social history
- Salient medical/ biological history
- Salient developmental issues
- Family history of mental illness/suicidal behaviour
- Current domestic and social circumstances, including relationships and occupation
- Salient substance use issues
- Medications

O – 'Objective'

Comments on current mental state examination*

Allergies

*Mandatory field for Medicare requirements

Relevant physical examination and other investigations

Results of relevant previous psychological and developmental testing

A – 'Assessment'

Risk assessment – If high level of risk indicated, document actions taken in the treatment plan below*

	Ideation/thoughts	Intent	Plan
Suicide			
Self-harm			
Harm to others			

Comments or details of any identified risks

*Mandatory field for Medicare requirements

Assessment/outcome tool used (except where clinically inappropriate)*

Case formulation and provisional diagnosis of mental health disorder*

P – 'Plan'

Patient goals

Setting personal recovery goals

*Mandatory field for Medicare requirements

Treatments and interventions*

Referrals*

Role of carer/support person

Intervention/relapse prevention plan (if appropriate at this stage)*

*Mandatory field for Medicare requirements

Other healthcare providers and service providers involved in patient's care (eg psychologist, psychiatrist, social worker, occupational therapist, other GPs, other medical specialists, case worker, community mental health services)

Role	Name	Address	Phone

Completing the plan*

On completion of the plan, the GP may record (tick boxes below) that they have:

- Discussed the assessment with the patient
- Discussed all aspects of the plan and the agreed date for review
- Offered a copy of the plan to the patient and/or their carer (if agreed by patient)

Date plan completed / /

Plan added to the patient's records? Yes No

Copy of the plan offered to other providers? Yes No

Record of patient consent

I, , agree to information about my health being recorded in my medical file and being shared between the GP and other healthcare providers involved in my care, as nominated above, to assist in the management of my healthcare. I understand that I must inform my GP if I wish to change the nominated people involved in my care.

I understand that as part of my care under this Mental Health Treatment Plan, I should attend the general practice for a review appointment at least four weeks, but no later than six months, after the plan has been developed.

I consent to the release of the following information to the following carer/support and emergency contact persons.

Name

Assessment: No Yes, with the following limitations:

Treatment plan: No Yes, with the following limitations:

Name

Assessment: No Yes, with the following limitations:

Treatment plan: No Yes, with the following limitations:

Signature of patient

Date / /

I, , have discussed the plan and referral/s with the patient.

GP Mental Health Treatment Plan included: No Yes (if yes, please select below)

MBS item number: 2700 2701 2715 2717

Signature of GP

Date / /

*Mandatory field for Medicare requirements

Letter of request for services

Date: / /

To:

Subject:

Dear Dr

I am referring

for

I am referring

date of birth: / / for sessions.

I have been primary care physician for the past years.

In summary, the following assessment and treatment planning has been undertaken:

Mental Health Treatment Plan attached: Yes No

Specific treatment requests:

If you have any questions, please feel free to contact me directly. I will be available on phone

and email in case of any query.

Looking forward to your reply.

Yours sincerely,

Review

MBS item number: 2712 2719

Planned date for review with GP (Initial review four weeks to six months after completion of plan)

Actual date of review with GP*

Assessment/outcome tool results on review (except where clinically inappropriate)*

Comments – review of patient's progress against goals, checking, reinforcing and expanding education, modification of treatment plan (if required)*

Intervention/relapse prevention plan (if appropriate)*

*Mandatory field for Medicare requirements

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