Patient wellbeing assessment and recovery plan

Children and adolescents

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 ☐☐ / ☐☐ / ☐☐

Was patient involved in discussion with GP about treatment plan? ☐ Yes ☐ No

Was parent/guardian involved in discussion with GP about patient's treatment plan? ☐ Yes ☐ No

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

Parent/guardian details

First parent/guardian:

Relationship

Phone number 1

Phone number 2

Has patient consented for this treatment plan to be released to parents/guardians? ☐ Yes ☐ No

With the following restrictions

Second parent/guardian:

Relationship

Phone number 1

Phone number 2

Has patient consented for this treatment plan to be released to parents/guardians? ☐ Yes ☐ No

With the following restrictions

Emergency contact person details

First contact

Relationship

Phone number 1

Phone number 2

Patient/parent/guardian consent for healthcare team to contact emergency contacts? ☐ Yes ☐ No

Second contact

Relationship

Phone number 1

Phone number 2

Patient/parent/guardian consent for healthcare team to contact emergency contacts? ☐ Yes ☐ No

Schooling (if applicable)

Current school level

Name of school/preschool

Salient school factors

Patient/guardian consent to discuss GPMHTP with the following members of school community:

	Role	Name	Phone
☐ Yes	Principal		
☐ Yes	Assistant Principal/s		
☐ Yes	Teacher/s		
☐ Yes	School counsellor/s		
☐ Yes	Other		

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 issues

Patient wellbeing and assessment

Reasons for presenting*

History of current episode*

Implications of symptoms on child/adolescent's daily activities

*Mandatory field for Medicare requirements

Patient history*

Mental health history

Salient social history*

Salient medical/biological history*

*Mandatory field for Medicare requirements

Salient developmental issues

Family history of mental illness

Current domestic and social circumstances

Salient substance use issues

Current medications

History of medication and other treatments for mental illness

Allergies

Relevant physical examination and other investigations

Results of relevant previous psychological and developmental testing

Other care plan ☐ No ☐ Yes, specify:

Comments on strengths and positive dispositions

Comments on current mental state examination

Trauma-informed care and practice (TICP) assessment

Consider possible influence of trauma

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

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

*Mandatory field for Medicare requirements

Date of assessment*

Results* ☐ Copy of completed tool provided to referred practitioner

Provisional diagnosis of mental health disorder*

*Mandatory field for Medicare requirements

Case formulation*

Other relevant information from carer/informants

Any other comments

*Mandatory field for Medicare requirements

Personal recovery plan

1. Identified issues/problems

Issue 1:

Issue 2:

Issue 3:

2. Goals*

Issue 1:

Issue 2:

Issue 3:

*Mandatory field for Medicare requirements

3. Treatments and interventions*

Issue 1:

Issue 2:

Issue 3:

*Mandatory field for Medicare requirements

4. Referrals*

Issue 1:

Issue 2:

Issue 3:

*Mandatory field for Medicare requirements

5. Any role of carer/support person/s

Issue 1:

Issue 2:

Issue 3:

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

Psycho-education provided if not already addressed in 'Treatments and interventions' above?* ☐ Yes ☐ No

Plan added to the patient's records? ☐ Yes ☐ No

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

*Mandatory field for Medicare requirements

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 ☐☐ / ☐☐ / ☐☐

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

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)

*Mandatory field for Medicare requirements

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

We acknowledge the Traditional Custodians of the lands and seas on which we work and live, and pay our respects to Elders, past, present and future.