Patient wellbeing assessment and management plan: Minimal requirements

(GP Mental Health Treatment Plan)

Note: 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 ☐ 281 ☐ 282

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

Major headings are **bold**; prompts to consider lower case; **Underlined** items of either bold or lower case are mandatory for compliance with Medicare requirements.

Contact and demographic details

GP name

GP phone number

General practice name

GP fax number

General practice address

Provider number

Patient last name

Date of birth (dd/mm/yyyy)

Patient first name/s as per Medicare card

Patient preferred name

Pronouns: ☐ She/her/hers ☐ He/him/his ☐ They/them/theirs ☐ Other:

Sex assigned at birth: ☐ Male ☐ Female ☐ Intersex ☐ Another term:

Gender: ☐ Male ☐ Female ☐ Transgender ☐ Non-binary ☐ Gender diverse

☐ Different term: ☐ Do not know ☐ Prefer not to answer

Patient address

Patient phone number

Medicare number

Health Care Card/Pensioner Concession Card number

Can leave a message? ☐ Yes ☐ No

Emergency contact person details (Option to record more than one contact)

1. Name Contact number

2. Name Contact number

3. Name Contact number

Patient consent for healthcare team to contact emergency contacts?

☐ Yes ☐ No

Information that cannot be shared with emergency contacts and/or carers

Carer/next of kin name, phone number and email address

Record:

- Who else can the healthcare team contact to discuss care of the patient?
- Who else is involved in making decisions for the patient?

Preferred languages spoken: ☐ English ☐ Other:

Interpreter required: ☐ No ☐ Yes, comments:

Country of birth: ☐ Australia ☐ Other:

Patient wellbeing assessment

Reasons for presenting

Consider asking:

- What are the patient's current mental health issues?
- What requests and hopes does the patient have?

Patient history

Record:

- Relevant medical/biological information
- mental health/psychological information
- social history

Medications and psychotropics (if relevant)

Consider asking about:

- current medications
- date of commencement/recent change of dose
- medications previously prescribed

Results of the Mental State Examination

Record:

- appearance, cognition, thought process, thought content, attention, memory, insight, behaviour, speech, mood and affect, perception, judgement, orientation

Risk assessment

Note any identified risks, including risks of self-harm and harm to others, ideation/thoughts, intent or plans

Assessment/outcome tool used and the results (except where clinically inappropriate and culturally unsafe)

Provisional diagnosis of mental health disorder

Case formulation

Consider:

- Patient's perception of the origin of their illness, spiritual views and beliefs
- Presenting
- Predisposing
- Precipitating
- Perpetuating
- Protective

Setting personal recovery goals: Considerations

Consider asking about:

- what recovery looks like for the patient
- the person themselves prioritising the goal/s to focus on
- which strengths and positive dispositions (eg abilities, talents, interests) are relevant and be can built in to pursue goals

Personal management plan

Identified issues/problems	**Goals** Record goals made in collaboration with the patient (also goals for future treatments, longer-term goals)	**Treatments and interventions** • Actions and support services required to achieve patient goals • Actions to be taken by the patient. Consider: • psychological and/or pharmacological options • face-to-face options • internet-based options: – myCompass – THIS WAY UP – MindSpot – e-couch – moodgym – Mental Health Online – OnTrack • Australian Psychologist Society (APS): – Find a Psychologist	**Referrals** Support services or local groups that are culturally appropriate. Consider: • referral to internet-based mental health programs for education and/or specific psychotherapy, such as: – myCompass – THIS WAY UP – MindSpot – e-couch – moodgym – Mental Health Online – OnTrack – Headspace (national)

Intervention/relapse-prevention plan

If appropriate at this stage, note arrangements to intervene in case of relapse or crisis

Psychoeducation provided? ☐ Yes ☐ No

Patient consent for having their plan recorded in their medical records? ☐ Yes ☐ No

Patient consent for sharing their plan with other healthcare providers? ☐ Yes ☐ No

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

Completing the plan

On completion of the plan, record (tick boxes below) that you 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 the patient)

Date plan completed (dd/mm/yyyy)