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| **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.  ***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 no.** | | |  | | | | | | | | **Health Care Card no.** | | | | | |  | | | |
| **Parent/guardian details** | | | | | | | | | | | **Has patient consented for this treatment plan to be released to parents/guardians?** | | | | | | | | | |
| First parent/guardian: | | | Relationship: | | | | | Phone number 1:  Phone number 2: | | | Yes  With the following restrictions: | | | | | | | | No | |
| Second parent/guardian: | | | Relationship: | | | | | Phone number 1:  Phone number 2: | | | Yes  With the following restrictions: | | | | | | | | No | |
| **Emergency contact person details** | | | | | | | | | | | **Patient/parent/guardian consent for healthcare team to contact emergency contacts?** | | | | | | | | | |
| First contact: | | | | Relationship: | | | | | Phone number 1:  Phone number 2: | | Yes | | | | | | | No | | |
| Second contact: | | | | Relationship: | | | | | Phone number 1:  Phone number 2: | | Yes | | | | | | | No | | |
| **Schooling (if applicable)** | | | | | | | | | | | | | | | | | | | | |
| **Current school level** | |  | | | | **Name of school/preschool** | | | | | | | |  | | | | | | |
| **Salient school factors**  Consider asking:   * Has there been any prior disruption to schooling? * What is the current frequency of school attendance? * What is the patient’s ability to start and finish homework? * How are the patient’s peer relationships? * Has the patient experienced any bullying? * Has the patient experienced any traumatic school community events? | |  | | | | | | | | | | | | | | | | | | |
| **Patient/guardian consent to discuss GPMHTP with the following members of school community:** | | | | | | | | | | | | | | | | | | | | |
|  | **Role** | | | | | | **Name/s** | | | | | | | | **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** | | | | |  | | | | | | | | | | | | | | | |

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| **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? | |  | | | |
| **History of current episode**  Consider asking about:   * Symptom onset, duration, intensity, time course | |  | | | |
| **Implications of symptoms on child/adolescent’s daily activities** | |  | | | |
| **Patient history**  Consider: | |  | | | |
| * Mental health history | |  | | | |
| * Salient social history | |  | | | |
| * Salient medical/biological history * ♀ – menarche, menstruation, pregnancy | |  | | | |
| Salient developmental issues | |  | | | |
| **Family history of mental illness**  Consider asking about:   * Family history of suicidal behaviour * Genogram | |  | | | |
| **Current domestic and social circumstances**  Consider asking about:   * Living arrangements * Siblings * Custodial arrangements * Social relationships   Engagement with peers | |  | | | |
| **Salient substance use issues**  Consider asking about:   * Nicotine use * Alcohol use * Illicit substances * Is patient willing to address the issues? | |  | | | |
| **Current medications**  Consider asking about:   * Dosage, date of commencement, date of change in dosage * Reason for the prescription * Are there other practitioners involved in the prescription of medication? * Are there issues with compliance or misuse? | |  | | | |
| **History of medication and other treatments for mental illness**  Consider asking about:   * School counselling and other school interventions * Past referrals * Effectiveness of previous treatments * Side effects and complications associated with previous treatments * Patient’s preference for medications | |  | | | |
| **Allergies** | |  | | | |
| **Relevant physical examination and other investigations** | |  | | | |
| **Results of relevant previous psychological and developmental testing** | |  | | | |
| **Other care plan**  E.g. GP Management Plans and Team Care Arrangements;  Wellness Recovery Action Plan | | Yes, specify:    No | | | |
| **Comments on strengths and positive dispositions** | | | | | |
| Consider asking about:   * Abilities, talents and interests * Competencies and accomplishments * Previous self-help strategies used and those available in the family support network * Service system and the community at large | |  | | | |
| **Comments on current mental state examination** | | | | | |
| Consider:   * Appearance, cognition, thought process, thought content, attention, memory, insight, behaviour, speech, mood and affect, perception, judgement, orientation |  | | | | |
| **Trauma-informed care and practice (TICP) assessment** | | | | | |
| **Consider possible influence of trauma**  Trauma can be defined as:   * Exposure to death * Threatened death * Actual serious injury * Threatened serious injury * Actual sexual violence   Threatened sexual violence | |  | | | |
| **Risk assessment –**  **If high level of risk indicated, document actions taken in treatment plan below**  Consider asking:   * Does the patient have a timeline for acting on a plan? * How bad is the pain/distress experienced? * Is it interminable, inescapable, intolerable? |  | | **Ideation/thoughts** | **Intent** | **Plan** |
| **Suicide** | |  |  |  |
| **Self-harm** | |  |  |  |
| **Harm to others** | |  |  |  |
| **Comments or details of any identified risks** | | | | |
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| **Assessment/outcome tool used,**  (except where clinically inappropriate)   * e.g., Strengths and Difficulties Questionnaire * Note: K-10 is not validated for minors | | |  | | |
| **Date of assessment** | | |  | | |
| **Results** | | | Copy of completed tool provided to referred practitioner | | |
| **Provisional diagnosis of mental health disorder**  Consider conditions specified in the ICPC, including:   * Anxiety co-morbid with autism * ADD/ADHD * Conduct disorder * Oppositional defiant disorder * Mood disorder * Separation anxiety * Phobias * Elective mutism * Reactive attachment disorder * Nonorganic enuresis and encopresis * Eating disorder * Adjustment disorder (eg grief/loss/ parental separation/trauma/medical condition) * Depression * Anxiety * Unexplained somatic disorder * Mental disorder not otherwise specified | | |  | | |
| **Case formulation**  Consider asking about:   * Predisposing factors * Precipitating factors * Perpetuating factors * Protective factors | | |  | | |
| **Other relevant information from carer/informants**  Consider asking about:   * Specific concerns of carer/family * Impact on carer/family * Contextual information from members of patient’s community * Other content from individuals other than the patient | | |  | | |
| **Any other comments** | | |  | | |

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| **Personal recovery plan** | | | | |
|  |  | **Actions** | | |
| **Identified issues/problems**  Consider:   * As presented by patient * Developed during consultation * Formulated by GP | **Goals**  Consider:   * Goals made in collaboration with patient * What does the patient want to see as an outcome from this plan? * Wellbeing, function, occupation, relationships * Any reference to special outcome measures * Time frame | **Treatments & interventions**  Consider:   * Suggested psychological interventions * Medications * Key actions to be taken by patient * Support services to achieve patient goals * Role of GP * Psycho-education * Time frame * Internet-based options:   + [myCompass](https://www.mycompass.org.au/)   + [THIS WAY UP](https://thiswayup.org.au/)   + [MindSpot](http://www.mindspot.org.au/)   + [e-couch](https://ecouch.anu.edu.au/welcome)   + [moodgym](https://moodgym.anu.edu.au/welcome)   + [Mental Health Online](https://www.mentalhealthonline.org.au/)   + [OnTrack](https://www.ontrack.org.au/web/ontrack) | **Referrals**  Consider:   * Practitioner, service or agency – referred to whom and what for * Specific referral request * Opinion, planning, treatment * Case conferences * Time frame * Referral to internet mental health programs for education:   + [myCompass](https://www.mycompass.org.au/)   + [THIS WAY UP](https://thiswayup.org.au/)   + [MindSpot](http://www.mindspot.org.au/)   + [e-couch](https://ecouch.anu.edu.au/welcome)   + [moodgym](https://moodgym.anu.edu.au/welcome)   + [Mental Health Online](https://www.mentalhealthonline.org.au/)   + [OnTrack](https://www.ontrack.org.au/web/ontrack) | **Any role of carer/support person(s)**  Consider:   * Identified role or task/s (eg monitoring, intervention, support) * Discussed, agreed, and negotiated with carer? * Any necessary supports for carer * Time frame |
| **Issue 1:** |  |  |  |  |
| **Issue 2:** |  |  |  |  |
| **Issue 3:** |  |  |  |  |
| **Intervention/relapse prevention plan** (if appropriate at this stage)  Consider asking about:   * Warning signs from past experiences * Arrangements to intervene in case of relapse or crisis * Support services currently in place * Any past effective strategies | |  | | |
| **Psycho-education provided if not already addressed in ‘Treatments and interventions’ above?** | | | Yes No | |
| **Plan added to the patient’s records?** | | | Yes No | |

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| **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** |
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| **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** |
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| **Record of consent** | | | | | |
| I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_[name of patient or parent/guardian as applicable], agree to information about my/my charge’s health being recorded in my medical file and being shared between the GP and other healthcare providers involved in my/his/her care, as nominated above, to assist in the management of my/my charge’s healthcare. I understand that I must inform my GP if I wish to change the nominated people involved in my/my charge’s care.  I understand that as part of my/my charge’s care under this Mental Health Treatment Plan, I/he/she 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** | | | **Treatment plan** | |
|  | **Yes** | | **No** | **Yes** | **No** |
|  | With the following limitations: | |  | With the following limitations: |  |
|  | With the following limitations: | |  | With the following limitations: |  |
| \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Signature of patient or guardian | | \_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_  Date | | | |
| I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, have discussed the plan and referral/s with the patient.  Full name of GP | | | | | |
| **Mental Health Treatment Plan included:**  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Signature of GP | | **No**  **Yes (if yes, please select below)**  **MBS item number:**  2700  2701  2715  2717  \_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_  Date | | | |

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| **Request for services** |

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| Date:  To:  [Attn]  [Address]  [Post code]  **Subject:** Letter of request for services  Dear Dr  I am referring [patient’s name] for  I am referring [patient’s name] [date of birth] for [number of sessions] sessions.  I have been [patient’s name]’s primary care physician for the past [number of years] 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 [T+00000000] and email [email@email.com] in case of any query.  Looking forward to your reply.  Yours sincerely,  [Signature]    [Physician’s name and title]    [Provider number] |

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| **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**  Consider:   * Progress on goals and actions * Identified actions have been initiated and followed through (e.g. referrals, appointments, attendance) * Checking, reinforcing and expanding education * Communication between the GP and patient * Where appropriate, communication received from referred practitioners * Modification of treatment plan if required |  |
| **Intervention/relapse prevention plan** (if appropriate)  Consider:   * Warning signs from past experiences * Arrangements to intervene in case of relapse or crisis * Other support services currently in place * Any past effective strategies |  |