

**GP MENTAL HEALTH TREATMENT PLAN (MBS ITEM NUMBER 2710)  
PATIENT ASSESSMENT**

<b>Patient's Name</b>	<b>Date of Birth</b>						
<b>Address</b>	<b>Phone</b>						
<b>Carer details and/or emergency contact(s)</b>	<table border="0"> <tr> <td><b>Other Care Plan</b></td> <td>Yes</td> <td>θ</td> </tr> <tr> <td><i>e.g. GPMP / TCA</i></td> <td>No</td> <td>θ</td> </tr> </table>	<b>Other Care Plan</b>	Yes	θ	<i>e.g. GPMP / TCA</i>	No	θ
<b>Other Care Plan</b>	Yes	θ					
<i>e.g. GPMP / TCA</i>	No	θ					
<b>GP Name</b>	<b>Practice</b>						
<b>AHP or nurse currently involved in patient care</b>	<b>Medical Records No</b>						

<b>PRESENTING ISSUE(S)</b> What are the patient's current mental health issues	
<b>PATIENT HISTORY</b> Record relevant biological psychological and social history including any family history of mental disorders and any relevant substance abuse or physical health problems	
<b>MEDICATIONS</b> (attach information, if required)	
<b>ALLERGIES</b>	
<b>SUBSTANCE ABUSE ISSUES</b>	
<b>ANY OTHER RELEVANT INFORMATION</b>	
<b>RESULTS OF MENTAL STATE EXAMINATION</b> Record after patient has been examined	
<b>RISK AND CO-MORBIDITIES</b> Note any associated risks and co-morbidities including risks of self harm and/or harm to others	
<b>OUTCOME TOOL USED</b>	<b>RESULTS</b>

<b>DIAGNOSIS OF MENTAL HEALTH DISORDER</b>
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<b>PERSON HISTORY / LIFESTYLE ISSUES</b> (e.g. childhood, substance abuse, relationship history, coping with previous stressors)

<b>RELEVANT PHYSICAL AND MENTAL EXAMINATION</b>

<b>INVESTIGATIONS</b>					
<b>Attached</b>	Yes	θ	<b>Not attached</b>	Yes	θ
	No	θ		No	θ

<b>MENTAL STATUS EXAMINATION</b>					
Appearance and General Behaviour	Normal	θ	Mood (Depressed / Labile)	Normal	θ
	Other	θ		Other	θ
Thinking (Content/Rate/Disturbances)	Normal	θ	Affect (Flat / blunted)	Normal	θ
	Other	θ		Other	θ
Perception (Hallucinations, etc)	Normal	θ	Sleep (Initial Insomnia / Early Morning Wakening)	Normal	θ
	Other	θ		Other	θ
Cognition (Level of Consciousness / Delirium / Intelligence)	Normal	θ	Appetite (Disturbed Eating Patterns)	Normal	θ
	Other	θ		Other	θ
Attention / Concentration	Normal	θ	Motivation / Energy	Normal	θ
	Other	θ		Other	θ
Memory (Short and Long Term)	Normal	θ	Judgement (Ability to make rational decisions)	Normal	θ
	Other	θ		Other	θ
Insight	Normal	θ	Anxiety Symptoms (Physical and Emotional)	Normal	θ
	Other	θ		Other	θ
Orientation (Time / Place / Person)	Normal	θ	Speech (Volume /Rate /Content)	Normal	θ
	Other	θ		Other	θ

<b>RISK ASSESSMENT</b>			
<b>Suicidal Ideation</b>		<b>Suicidal Intent</b>	
<b>Current Plan</b>		<b>Risk to Others</b>	

<b>KEY FAMILY / SUPPORT CONTACT</b>



**GP MENTAL HEALTH TREATMENT PLAN (MBS ITEM NUMBER 2710)**

**PATIENT PLAN**

<p><b>PATIENT NEEDS / MAIN ISSUES</b> Relate to treatable diagnosis</p>	<p><b>GOALS</b> Record the mental health goals agreed to by the patient and GP and any actions the patient will need to take</p>	<p><b>TREATMENTS</b> Treatments, actions, and support services to achieve patient goals</p>	<p><b>REFERRALS</b> <i>NOTE:</i> 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</p>
<p><b>CRISIS / RELAPSE</b> If required, note the arrangements for crisis intervention and/or relapse prevention</p>			

<p><b>APPROPRIATE PSYCHO-EDUCATION PROVIDED</b></p>	<p>Yes    <input type="checkbox"/> No      <input type="checkbox"/></p>	<p><b>PLAN ADDED TO THE PATIENT'S RECORDS</b></p>	<p>Yes    <input type="checkbox"/> No      <input type="checkbox"/></p>	<p><b>COPY (OR PARTS) OF THE PLAN OFFERED TO OTHER PROVIDERS</b></p>	<p>Yes      <input type="checkbox"/> No        <input type="checkbox"/> Not Required   <input type="checkbox"/></p>
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<p><b>COMPLETING THE PLAN</b> On completion of the plan, the GP is to record that he/she has discussed with the patient:</p> <ul style="list-style-type: none"> <li>* the assessment</li> <li>* all aspects of the plan and the agreed date for review; and</li> <li>* offered a copy of the plan to the patient and/or their carer (if agreed by the patient)</li> </ul>	
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<p><b>DATE PLAN COMPLETED</b></p>	<p><b>REVIEW DATE</b> (Initial review four weeks to six months after completion of plan)</p>
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<p><b>REVIEW COMMENTS</b> (Progress on actions and tasks) <i>NOTE:</i> If required, a separate form may be used for the Review</p>	<p><b>OUTCOME TOOL RESULTS ON REVIEW</b></p>
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# K10

For all questions, please fill in the appropriate circle. Fill in the circles like this ●. Please do not tick or cross the circles.

In the past four weeks	None of the time	A little of the time	Some of the time	Most of the time	All of the time
1. About how often did you feel tired out for no good reason?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
2. About how often did you feel nervous?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
3. About how often did you feel so nervous that nothing could calm you down?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
4. About how often did you feel hopeless?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
5. About how often did you feel restless or fidgety?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
6. About how often did you feel so restless you could not sit still?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
7. About how often did you feel depressed?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
8. About how often did you feel that everything is an effort?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
9. About how often did you feel so sad that nothing could cheer you up?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
10. About how often did you feel worthless?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

*Today's Date*        /   /

# Better Access Mental Health Treatment Plan (Review)

Item No: 2712 (Review)

<b>GP Mental Health Care Review</b>	<b>Date:</b> (4 weeks to 6 months from date of Plan)	
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<b>Patient Name:</b>			<b>Outcome Tool K10</b>	<b>Result</b>	
<b>DOB:</b>		<b>Gender:</b>		<b>Date:</b>	
<b>GP Name:</b>					

<b>PROBLEM / DIAGNOSIS</b>		
	<b>Goal</b>	<b>Progress on Actions and Tasks</b>
<b>Number 1:</b>		
<b>Number 2:</b>		
<b>Number 3:</b>		

<b>FOLLOW UP RELAPSE PREVENTION PLAN</b>

<b>RE-REFERRAL SECTION</b> (if further Allied Health Practitioner sessions required - maximum of six further sessions)

<b>RECORD OF PATIENT CONSENT</b>		
I, _____, ( <b>patient</b> name – please print clearly) <b>consent to this Treatment Plan to proceed and I agree to</b> information about my mental health being recorded in my medical file and being shared between the GP and the counsellor(s) to whom I am referred, to assist in the management of my health care.		
_____ (Signature of Patient)	_____ (Date)	
I, _____, (GP) have discussed the proposed referral(s) with the patient and I am satisfied that the patient understands the proposed uses and disclosures and has provided their informed consent to these.		
_____ (Signature of GP)	_____ (Name of GP)	_____ (Date)