GP MENTAL HEALTH CARE PLAN (MBS ITEM NUMBER 2710) **PATIENT ASSESSMENT**			
Patient's Name		**Date of Birth**	
Address		**Phone**	
Carer details and/or emergency contact		**Other care plan** e.g.GPMP / TCA	
GP Name / Practice			
AHP or nurse currently involved in patient care		**Medical Records No.**	

PATIENT CONSENT Patient has agreed to GP Mental Health Care Plan service	(signature)
PRESENTING ISSUE(S) What are the patient's current mental health issues	
PATIENT HISTORY Record relevant • **biological** • **psychological** and • **social history** including any • **family history of mental disorders** and any relevant • **substance abuse** or • **physical health problems**	
MEDICATIONS (attach information if required)	
ALLERGIES	
OTHER RELEVANT INFORMATION	
RESULTS OF MENTAL STATE EXAMINATION Record after patient has been examined (refer to table on last page of template)	
RISKS AND CO-MORBIDITIES Note any associated risks and co-morbidities including suicidal tendencies and risks to others	

OUTCOME TOOL USED		**RESULTS**	
DIAGNOSIS			

GP MENTAL HEALTH CARE PLAN (MBS ITEM NUMBER 2710)

PATIENT PLAN

PATIENT NEEDS / MAIN ISSUES	**GOALS** Record the mental health goals agreed to by the patient and GP and any actions the patient will need to take.	**TREATMENTS** Treatments, actions and support services to achieve patient goals.	**REFERRALS** Note: 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.

CRISIS / RELAPSE If required, note the arrangements for crisis intervention and/or relapse prevention.	

APPROPRIATE PSYCHO-EDUCATION PROVIDED		**PLAN ADDED TO THE PATIENT'S RECORDS**		**COPY (OR PARTS) OF THE PLAN OFFERED TO OTHER PROVIDERS**	

COMPLETING THE PLAN On completion of the plan, the GP is to record that s/he has discussed with the patient: -the assessment; -all aspects of the plan and the agreed date for review; and -offered a copy of the plan to the patient and/or their carer (if agreed by patient)	
DATE PLAN COMPLETED:	**REVIEW DATE:** (initial review 4 weeks to 6 months after completion of plan)
<u>REVIEW - MBS ITEM 2712</u> **REVIEW COMMENTS** (Progress on actions and tasks) Note: If required, a separate form may be used for the Review.	**OUTCOME TOOL** **RESULTS ON REVIEW**

Mental State Examination (complete relevant aspects)**:**

Appearance & General Behaviour	
Mood (depressed/ labile)	
Thinking (content/rate/disturbance)	
Affect (flat/blunted)	
Perception (hallucinations etc)	
Appetite (disturbed eating patterns)	
Attention/concentration	
Motivation/energy	
Memory (short and long term)	
Insight	
Anxiety symptoms (physical and emotional)	
Orientation (time/place/ person)	
Sleep (initial insomnia/ early morning wakening)	
Cognition (level of consciousness/delirium/ intelligence)	
Judgment (ability to make rational decisions)	

healthfocus
clinical psychology services

Armadale-
Ph: 08 9399 1911 Fax: 08 9399 5669
Shop 6 Pioneer Village Complex
7 Albany Hwy Mt Richon WA 6112
Riverton-
Ph: 08 6369 1191 Fax: 08 6153 1091
Unit 1 2 Madeira Rd Parkwood WA 6147
PO Box 339 Armadale WA 6992
www.healthfocuspsychology.com.au

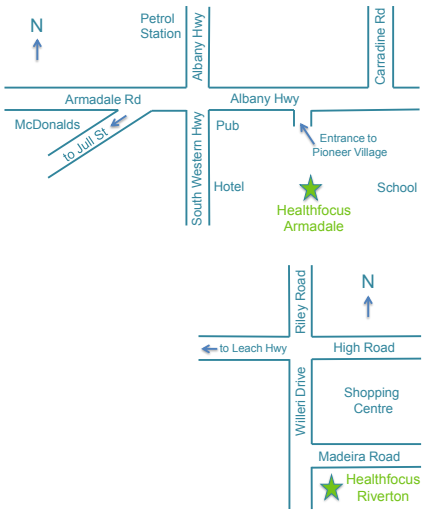
Name: _____ DOB: _____

❑ Next available psychologist or ❑ Preferred psychologist: _____

REASON FOR REFERRAL

- ❑ Depression
- ❑ Anxiety
- ❑ Trauma reaction
- ❑ Pain management
- ❑ Women's health (pregnancy, childbirth, postnatal)
- ❑ Work stress
- ❑ Coping with injury or illness
- ❑ Grief/loss issues
- ❑ Relationship counselling
- ❑ Positive parenting
- ❑ Eating and body image issues
- ❑ Obsessive Compulsive Disorder
- ❑ Learning and developmental issues
- ❑ Hypnotherapy
- ❑ Sex therapy
- ❑ Other _____

- ❑ Workers Compensation
- ❑ Personal Injury / Motor Vehicle Accident



Comments:

Referring Doctor: _____

Signature: _____ Date: _____