Grand Pacific Health

MENTAL HEALTH TREATMENT PLAN

PATIENT ASSESSMENT

Patient information			
Name:			
Date of birth:	Age:	Sex: Male Female	
Address:			
Phone (home):	Phone (mobile):		
Phone (work):	Medicare number:		
Emergency contact:			
Aboriginal or Torres Strait Islander:			
General practitioner details			
GP name:	Practice name:		
Medicare provider number:	Phone:	Fax:	
GP address:		Post code:	
Assessment details			
Date of assessment, plan and referral:			
Other care plan (e.g. GPMP/TCA):			
AHP or nurse currently involved in patient care:			
Level of priority of consultation:			
Risk assessment			
Medications			
Allergies			

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Presenting issues

What are the patient's current mental health issues?

☐ Anxiety	☐ GAD	☐ OCD	☐ Social phobia	
	☐ PTSD	☐ Panic disorder	☐ Agoraphobia	
☐ Mood disorder	☐ Depression	☐ Dysthymia		
☐ Perinatal (ante/post natal)	☐ Depression	☐ Anxiety (incl PTSD)	☐ Psychosis	
☐ Serious mental illness	☐ Schizophrenia	☐ Schizoaffective disorder	☐ Other	
☐ Personality disorder	☐ Borderline	☐ Antisocial	☐ Avoidant	☐ Dependent
☐ Other issues	Specify:			
☐ Substance use or misuse	Specify:			

History of presenting issues

E.g. when the problem first started, triggers, course of problem

Current mental state

Outcome tool

Relevant physical health problems

Relevant background issues

Previous trauma, abuse, sexual assault?

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Relevant background issues	
Family history of mental illness?	
☐ Autism spectrum (specify):	☐ Intellectual disability
☐ Behavioural problems	☐ Learning difficulty
☐ ADHD/ADD	☐ Language difficulty
☐ Conduct disorder	☐ Other (specify):
Social history	
Income status:	Relationship status:
Higher education level achieved:	Living situation:

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PATIENT CARE PLAN

Care plan				
Patient needs/main issues	Goals	Treatments	Referrals	Review

Crisis relapse plan
Tick the boxes if you agree:
☐ Appropriate psychoeducation provided?
☐ Plan added to the patient's records?
☐ Copy (or parts) of the plan offered to other providers?

Completing the plan	
In completing the mental health treatment plan, I have discussed with the patient: (tick relevant boxes)	
☐ The assessment	
☐ All aspects of the plan, including referrals to other providers	
☐ The possibility of a case conference with other care providers	
☐ 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:	Review date:

Referral and patient consent	
I _____ (GP name) am referring this patient for treatment. I have discussed the proposed referral with the patient and am satisfied that the patient understands the reason for the referral.	
GP signature:	Date:
I _____ (patient name) declare that my GP has explained why I have been referred to the above service. I agree to information about my mental health and wellbeing, medical and social history being shared between my GP and the appropriate staff involved in the management of my health care. I understand that this may occur during a case conference.	
Client signature:	Date:

If Grand Pacific Health (GPH) is to be the treatment provider, please send this completed Mental Health Treatment Plan to GPH via secure fax: 4226 6489 or GPH Argus (secure messaging): intake.argus@gph.org.au

Please note: GPH does not provide a crisis service. Patients with acute mental illness should be referred to the Mental Health Helpline: 1800 011 511 (24 hours)