

GP MENTAL HEALTH TREATMENT PLAN – MINIMAL REQUIREMENTS

Notes: This form is designed for use with the following MBS items. Users should be familiar with the most recent item definitions and requirements.

MBS ITEM NUMBER: ☐ 2700 ☐ 2701 ☐ 2715 ☐ 2717

Major headings are **bold**; prompts to consider lower case. Response fields can be expanded as required. Underlined items of either type are mandatory for compliance with Medicare requirements.

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	Dr Osese Ejembi	GP phone	(07)53167868
GP practice name	Ripley Medical and Skin Clinic	GP fax	(07)30099999
GP address	T20,20 Main Street, RIPLEY QLD 4306	Provider number	4976152W
Patient surname	Hurst	Date of birth	25/2/1981
Patient first name(s)	Kelly	Preferred name	Kelly
Gender	Female		
Patient address	8 Trevorrow Way, RIPLEY QLD 4306	Patient phone	0468353812
		Can leave message?	☐ Yes ☐ No
Medicare No.	4407 93894 2 / 2	Healthcare Card/Pension No.	
Emergency contact person details		Patient consent for healthcare team to contact emergency contacts?	☐ Yes ☐ No

PATIENT ASSESSMENT – MENTAL HEALTH

<u>Reasons for presenting</u>	low mood, insomnia, depression/anxiety low motivation tendency to procrastinate low self confidence/self esteem stress relationship problems
<u>Patient history</u> Record relevant <u>medical/</u> <u>biological, mental health/</u> <u>psychological, and social history</u>	depression/anxiety
<u>Results of mental state examination</u>	mse2
<u>Risk assessment</u> Note any identified risks, including risks of self-harm and harm to others	nil to self or others
<u>Assessment/outcome tool used and results,</u> except where clinically inappropriate	DASS 21
<u>Provisional diagnosis of mental health disorder</u>	depression/anxiety
<u>Case formulation</u>	protective factors - children

PLAN

Identified issues/problems	<u>Goals</u> Record goals made in collaboration with patient	<u>Treatments & interventions</u> Any actions and <u>support services</u> to achieve patient goals <u>Actions to be taken by patient</u> Consider: • psychological and/or pharmacological options • face to face options • internet-based options • <u>myCompass</u> • <u>THIS WAY UP</u> • <u>MindSpot</u> • <u>e-couch</u> • <u>MoodGYM</u> • <u>Mental Health Online</u> • <u>OnTrack</u>	<u>Referrals</u> <u>Or appropriate support services</u> Consider: • referral to internet mental health programs for education and/or specific psychotherapy • <u>myCompass</u> • <u>THIS WAY UP</u> • <u>MindSpot</u> • <u>e-couch</u> • <u>MoodGYM</u> • <u>Mental Health Online</u> • <u>OnTrack</u>
low mood, insomnia, depression/anxiety low motivation tendency to procrastinate low self confidence/self esteem ongoing stress relationship problems	-improve self esteem/self confidence -develop some coping strategies and skills in dealing with ongoing stress -improve low mood symptoms		psychologist input

<u>Intervention/relapse prevention plan</u> If appropriate at this stage, note arrangements to intervene in case of relapse or crisis		
<u>Psycho-education</u> provided?	☒ Yes ☐ No	
Plan added to the patient's records?	☒ Yes ☐ No	
<u>Completing the plan</u> On completion of the plan, the GP may record (tick boxes below) that s/he has:	Date plan completed	
☒ 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)		

RECORD OF PATIENT CONSENT

I, **Mrs Kelly Hurst** (*name of patient*), agree to information about my health being recorded in my medical file and being shared between the General Practitioner and other health care providers involved in my care, as nominated above, to assist in the management of my health care. I understand that I must inform my GP if I wish to change the nominated people involved in my care.

I understand that as part of my care under this Mental Health Treatment plan, I should attend the General Practitioner for a review appointment at least 4 weeks after but within 6 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)

I, **Dr Osese Eiembi**, have discussed the plan and referral(s) with the patient
(Full name of GP)

(Signature of GP)

15/04/2019
(Date)

REVIEW

MBS ITEM NUMBER: ☐ 2712 ☐ 2719

Planned date for review with GP
(initial review 4 weeks to 6 months
after completion of plan)

Actual date of review with GP

**Assessment/outcome tool
results on review.**
except where clinically
inappropriate

Comments
Review of patient's progress
against goals; checking,
re-enforcing and expanding
education; modification of
treatment plan if required

Plan for crisis intervention
and/or for relapse prevention. if
appropriate and if not previously
provided