GP Mental Health Treatment Plan (MBS Item 2710)

STEP 1: Assessment

Patient Details	**Patient Name**		**Medical Records number**	
	Address			
	Phone		**D.O.B**	
	Gender	☐ Male ☐ Female		
	Aboriginal/Torres Straight Islander?	☐ Aboriginal ☐ Torres Strait	☐ Neither ☐ Unknown	
GP Details	**General Practitioner**		**Provider Number**	
	Address			
	Phone		**Fax**	
Referral Details	**Allied Mental Health Provider involved in care**		**Phone**	
	Other Care Plan e.g. GPMP/TCA			
	ATAPS Referral ID		**ATAPS Referral Expiry date**	

Presenting Symptoms or Complaints		
History of Presenting Problems	**Past Medical History:**	
	Past Mental Health History:	
	Social History:	
	Family History:	
	Alcohol and/or Other drugs History:	
Medications:		
Allergies:		
Mental State Examination:	**Appearance:**	☐ Normal ☐ Other:
	Behaviour:	☐ Normal ☐ Other:
	Affect/Mood:	☐ Normal ☐ Other:
	Speech:	☐ Normal ☐ Other:
	Thought Form:	☐ Normal ☐ Other:
	Thought Content:	☐ Normal ☐ Other:
	Perceptual Disturbance:	☐ Normal ☐ Other:
	Cognition:	☐ Normal ☐ Other:
	Judgement:	☐ Normal ☐ Other:
	Insight:	☐ Normal ☐ Other:

Risk to Self	Suicide	☐ Yes ☐ No ☐ Unsure	Self Harm	☐ Yes ☐ No ☐ Unsure
Risk to Others	Risk to Others:	☐ Yes ☐ No ☐ Unsure		
Outcome Tool Used	☐ DASS 21 ☐ K10 ☐ Other:		Score:	
Diagnosis/Formulation				

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STEP 2: Care Plan

Patient Needs/Main Issues	Goals:	Treatments:	Referrals:
	Record the mental health goals agreed to by the patient and GP and any actions the patient will need to take	Treatments, actions and support services to achieve patient goals	Note: Referrals to be provided by GP, as required, in up to two groups of six sessions. The need for second group of sessions to be reviewed after the initial six sessions
		Initial action plan to be considered: Taking into account the issues that you and the patient have identified, summarise the initial action suggested (tick appropriate box) ☐ Diagnostic Assessment ☐ Psycho-education ☐ Interpersonal Therapy ☐ Cognitive Behaviour Therapy (CBT) ☐ Behavioural interventions ☐ Cognitive interventions ☐ Relaxation strategies ☐ Skills training ☐ Other CBT interventions ☐ Other (incl drug therapy) pls specify: ____________________	**Referred to:**____________________, for six (6) sessions. **Contact details of allied mental health provider:** Phone: Fax: ***Consider Referring to:*** ***BN3 Consulting*** ***Emalynne So*** ***Registered Psychologist*** ***60 Smart St*** ***Fairfield NSW 2165*** ***Suite 4, Level 2*** ***215-219 George St*** ***Liverpool NSW 2170*** ***Phone: (02) 9640 0522*** ***Fax: (02) 9012 0135***
Crisis/Relapse Note the arrangements for crisis intervention and/or relapse prevention			
Plan added to the Patient's Records	☐ Yes ☐ No	**Copy (or parts) of the plan offered to other Providers?**	☐ Yes ☐ No

Completing the plan: On completion of the plan, the GP is to record that s/he has discussed with the patient:

- the assessment ☐ Yes ☐ No
- all aspects of the plan and the agreed date for review ☐ Yes ☐ No
- offered a copy of the plan to the patient and/or their carer (if agreed by the patient) ☐ Yes ☐ No

Date plan completed:	**Review date:** (initial review 4 weeks to 6 months after completion of plan or after completion of 6 treatment sessions)

Review of the GP Mental Health Treatment Plan (MBS Item 2712)

STEP 3: Patient Review Date: ________

(initial review 4 weeks to 6 months after completion of plan)

Review comments (Progress on actions and tasks) Note: If required, a separate form (like this one) may be used for the Review

Make sure the review include:

- **Continuing consent by my patient:** ☐ Yes ☐ No
- **Review of the patient's progress.**
  Have you reviewed the progress report provided by the allied mental health provider?
  ☐ Yes ☐ No
- **Amend GP Mental Health Care Plan** ☐ Required ☐ Not required
- **Crisis and/or relapse prevention**
  Contact details for crisis support provided to patient?
  ☐ Yes If yes, who?________________________________.
  ☐ No
- **Re-administration of the outcome measurement tool (unless clinically inappropriate)**
  ☐ DASS 21 ☐ K10 ☐ Other:
  - **Score result:**

Do you think it is clinically appropriate to refer this patient for additional treatment sessions?

☐ Yes If yes and if this is an ATAPS referral please contact CSGPN to activate a patient ID number for further sessions

☐ No

☐ Not sure If not sure, discuss with treatment provider and/or patient

ATAPS Additional Sessions ID number (if relevant – a new ID number is required)		**ATAPS Additional Sessions expiry date** (four weeks from date new ATAPS Referral ID number obtained)	