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| **Patient wellbeing assessment** **and recovery plan** **– SOAP** | | | | | | |
| **Notes:** This form is designed for use with the following Medicare Benefits Schedule (MBS) items. Users should be familiar with the most recent item definitions and requirements.  **MBS item number:**  2700  2701  2715  2717  This document is **not** a referral letter. A referral letter must be sent to any additional providers involved in this Mental Health Treatment Plan.  *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.*** | | | | | | |
| **Contact and demographic details** | | | | | | |
| **GP name** |  | | **GP phone** | |  | |
| **GP practice name** |  | | **GP fax** | |  | |
| **GP address** |  | | **Provider number** | |  | |
| **Relationship** | **This person has been my patient since** | | | |  | |
| **and/or** | | | | | |
| **This person has been a patient at this practice since** | | | |  | |
| **Patient surname** |  | **Date of** **birth** (dd/mm/yy) | | |  | |
| **Patient first name/s** |  | **Preferred name** | | |  | |
| **Gender** | Female  Male  Self-identified gender: | | | | | |
| **Patient address** |  | | | | | |
| **Patient phone** | Preferred number:  Can leave message?  Yes  No | | | Alternative number:  Can leave message?  Yes  No | | |
| **Medicare no.** |  | | | **Health Care Card/Pensioner Concession Card no.** | |  |

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| **Carer/support person contact details** | | | | | | | | | **Has patient consented for this healthcare team to contact carer/support persons?** | | |
| First contact: | | Relationship: | | | Phone number 1:  Phone number 2: | | | | Yes  With the following restrictions: | | No |
| Second contact: | | Relationship: | | | Phone number 1:  Phone number 2: | | | | Yes  With the following restrictions: | | No |
| **Emergency contact person details** | | | | | | | | **Patient consent for healthcare team to contact emergency contacts?** | | | |
| First contact: | Relationship: | | | | | Phone number 1:  Phone number 2: | | Yes | | No | |
| Second contact: | Relationship: | | | | | Phone number 1:  Phone number 2: | | Yes | | No | |
| **Salient communication and cultural factors** | | | | | | | | | | | |
| **Language spoken at home** | | | | English | | | Other: | | | | |
| **Interpreter required** | | | | No | | | Yes, comments: | | | | |
| **Country of birth** | | | | Australia | | | Other: | | | | |
| **Other communication factors** | | |  | | | | | | | | |
| **Other relevant cultural factors** | | |  | | | | | | | | |

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| **S – ‘Subjective’** | |
| **Consider:**   * Reasons for presenting * History of current episode * Mental health history * Salient social history * Salient medical/biological history * Salient developmental issues * Family history of mental illness/suicidal behaviour * Current domestic and social circumstances, including relationships and occupation * Salient substance use issues * Current and previous medications, including effectiveness and side effects for mental disorders. |  |

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| **O – ‘Objective’** | |
| **Comments on current mental state examination**  Consider:   * Appearance, cognition, thought process, thought content, attention, memory, insight, behaviour, speech, mood and affect, perception, judgement, orientation * Appropriateness of Mini-Mental State Examination (MMSE) for patients aged ˃75 years or if otherwise indicated |  |
| **Allergies** |  |
| **Relevant physical examination and other investigations** |  |
| **Results of relevant previous psychological and developmental testing** |  |

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| **A – ‘Assessment’** | | | | |
| **Risk assessment –**  **If high level of risk indicated, document actions taken in the treatment plan below**  Consider asking:   * Does the patient have a timeline for acting on a plan? * How bad is the pain/distress experienced? * Is it interminable, inescapable, intolerable? |  | **Ideation/ thoughts** | **Intent** | **Plan** |
| **Suicide** |  |  |  |
| **Self-harm** |  |  |  |
| **Harm to others** |  |  |  |
| **Comments or details of any identified risks** | | | |
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| **Assessment/outcome tool used** (except where clinically inappropriate)  Include:   * Date of assessment * Results |  | | | |
| **Case formulation and provisional diagnosis of mental health disorder**  Consider asking about:   * Predisposing factors * Precipitating factors * Perpetuating factors * Protective factors   Consider conditions specified in the *International Classification of Primary Care*, 2nd edition |  | | | |

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| **P – ‘Plan’** | | | | | |
| **Patient goals**  **Setting personal recovery Goals**  Also consider:   * The person themselves prioritising the goal/s to focus on * The CHIME framework: connectedness, hope, identity, meaning and purpose, and empowerment * Which strengths are relevant and can be built on to pursue goal/s * How the person’s values, treatment and support preferences will impact on the action plan * Breaking goals down into smaller manageable steps and making plans for who will do what and when – informally or using the SMART (specific, meaningful, attainable, realistic, timetabled) approach * Supporting the person to undertake independent or joint actions rather than accepting passive actions | |  | | | |
| **Treatments and interventions**  Consider:   * Suggested psychological interventions * Medications * Key actions to be taken by patients * Support services to achieve patient goals * Role of GP * Psycho-education * Time frame * Internet-based options:   + [myCompass](https://www.mycompass.org.au/)   + [THIS WAY UP](https://thiswayup.org.au/)   + [MindSpot](http://www.mindspot.org.au/)   + [e-couch](https://ecouch.anu.edu.au/welcome)   + [moodgym](https://moodgym.anu.edu.au/welcome)   + [Mental Health Online](https://www.mentalhealthonline.org.au/)   + [OnTrack](https://www.ontrack.org.au/web/ontrack) | |  | | | |
| **Referrals**  Consider:   * Practitioner, service or agency – referred to whom, and for what * Specific referral request * Opinion, planning, treatment * Case conferences * Time frame * Referral to internet mental health programs for education:   + [myCompass](https://www.mycompass.org.au/)   + [THIS WAY UP](https://thiswayup.org.au/)   + [MindSpot](http://www.mindspot.org.au/)   + [e-couch](https://ecouch.anu.edu.au/welcome)   + [moodgym](https://moodgym.anu.edu.au/welcome)   + [Mental Health Online](https://www.mentalhealthonline.org.au/)   + [OnTrack](https://www.ontrack.org.au/web/ontrack) | |  | | | |
| **Role of carer/support person** | |  | | | |
| **Intervention/relapse prevention plan**  (if appropriate at this stage)  Consider asking about:   * Warning signs from past experiences * Arrangements to intervene in case of relapse or crisis * Support services currently in place * Any past effective strategies | |  | | | |
| **Other healthcare providers and service providers involved in patient’s care**  **(eg psychologist, psychiatrist, social worker, occupational therapist, other GPs, other medical specialists, case worker, community mental health services)** | | | | | |
| **Role** | **Name** | | **Address** | | **Phone** |
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| **Completing the plan** | | | | | |
| On completion of the plan, the GP may record (tick boxes below) that they have:  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) | | | | **Date plan completed** | |
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| **Plan added to the patient’s records?** | | | | Yes  No | |
| **Copy of the plan offered to other providers?** | | | | Yes  No  Not required | |

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| **Record of patient consent** | | | | | |
| I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_[name of patient], agree to information about my health being recorded in my medical file and being shared between the GP and other healthcare providers involved in my care, as nominated above, to assist in the management of my healthcare. 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 practice for a review appointment at least four weeks, but no longer than six 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 | | \_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_  Date | | | |
| I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, have discussed the plan and referral/s with the patient.  Full name of GP | | | | | |
| **Mental Health Treatment Plan Included:**  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Signature of GP | | **No**  **Yes (if yes, please select below)**  **MBS item number:**  2700  2701  2715  2717  \_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_  Date | | | |

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| **Request for services** |

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| Date:  To:  [Attn]  [Address]  [Post code]  Subject: Letter of request for services  Dear Dr  I am referring [patient’s name] for  I am referring [patient’s name] [date of birth] for [number of sessions] sessions.  I have been [patient’s name]’s primary care physician for the past [number of years] years.  In summary, the following assessment and treatment planning has been undertaken: [ ]  Mental Health Treatment Plan attached: Yes No  Specific treatment requests: [ ]  If you have any questions, please feel free to contact me directly. I will be available on phone [T+00000000] and email [email@email.com] in case of any query.  Looking forward to your reply.  Yours sincerely,  [Signature]    [Physician’s name and title]    [Provider number] |

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| **Review** | |
| **MBS item number:**  2712  2719 | |
| **Planned date for review with GP**  (Initial review four weeks to six 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, reinforcing and expanding education, modification of treatment plan (if required) |  |
| **Intervention/relapse prevention plan** (if appropriate) |  |