

Patient wellbeing assessment and recovery plan

Minimal requirements

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.

Contact and demographic details

GP name	GP phone
GP practice name	GP fax
GP address	Provider number
Patient surname	Date of birth (dd/mm/yy) / /
Patient first name/s	Preferred name

Gender: Female Male Self-identified gender:	
Patient address	Patient phone
Can leave message? Yes No	
Medicare number	Health Care Card number Pensioner Concession Card number

Emergency contact person details

Patient consent for healthcare team to contact emergency contacts?	Yes	No
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Patient wellbeing and assessment

Reasons for presenting*

Patient history*

Results of mental state examination*

Risk assessment*

*Mandatory field for Medicare requirements

Assessment/outcome tool used and results (except where clinically inappropriate)*

Provisional diagnosis of mental health disorder*

Case formulation*

Setting personal recovery goals – considerations

*Mandatory field for Medicare requirements

Personal recovery plan

1. Identified issues/problems

Issue 1:

Issue 2:

Issue 3:

2. Goals*

Issue 1:

Issue 2:

Issue 3:

*Mandatory field for Medicare requirements

3. Treatments and interventions*

Issue 1:

Issue 2:

Issue 3:

*Mandatory field for Medicare requirements

4. Referrals*

Issue 1:

Issue 2:

Issue 3:

*Mandatory field for Medicare requirements

Intervention/relapse prevention plan (if appropriate at this stage)*

Psycho-education provided if not already addressed in 'Treatments and interventions' above?* Yes No
 Plan added to the patient's records? Yes No

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 / /

Record of patient consent

I, _____, 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 later 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: No Yes, with the following limitations:

Treatment plan: No Yes, with the following limitations:

Name

Assessment: No Yes, with the following limitations:

Treatment plan: No Yes, with the following limitations:

Signature of patient

Date

/ /

I, _____, have discussed the plan and referral/s with the patient.

GP Mental Health Treatment Plan included: No Yes (if yes, please select below)

MBS item number: 2700 2701 2715 2717

Signature of GP

Date

/ /

*Mandatory field for Medicare requirements

Request for services

Date: / /

To:

Subject:

Dear Dr

I am referring

for

I am referring

date of birth: / / for sessions.

I have been primary care physician for the past 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

and email in case of any query.

Looking forward to your reply.

Yours sincerely,

Review

MBS item number: 2712 2719

Date for review with GP (Initial review four weeks to six months after completion of plan)*

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)*

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

*Mandatory field for Medicare requirements