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| **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.  *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** |  | |
| **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 no.** |  | **Health Care Card/Pensioner Concession Card no.** |  | |
| **Emergency contact person details** |  | **Patient consent for healthcare team to contact emergency contacts?** | | Yes  No |

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| **Patient wellbeing assessment** | |
| **Reasons for presenting** |  |
| **Patient history**  Record:   * Relevant medical/biological information * Mental health/psychological information * Social history |  |
| **Results of mental state examination** |  |
| **Risk assessment**  Note any identified risks, including risks of self-harm and harm to others |  |
| **Assessment/outcome tool used and results**  **(except where clinically inappropriate)** |  |
| **Provisional diagnosis of mental health disorder** |  |
| **Case formulation** |  |
| **Setting personal recovery goals – considerations**   * The patient 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 affect 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 |  |

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| **Personal recovery plan** | | | | | |
| **Identified issues/problems** | **Goals**  Record goals made in collaboration with patient | | **Treatments and interventions**   * Actions and support services to achieve patient goals * Actions to be taken by patient   Consider:   * Psychological and/or pharmacological options * Face-to-face options * 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**  Appropriate support services  Consider:   * referral to internet mental health programs for education and/or specific psychotherapy   + [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) |
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| **Intervention/relapse prevention plan**  If appropriate at this stage, note arrangements to intervene in case of relapse or crisis | |  | | | |
| **Psycho-education provided?** | | Yes No | | | |
| **Plan added to the patient’s records?** | | Yes No | | | |
| **Completing the plan**  On completion of the plan, record (tick boxes below) that you 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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| **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 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** | | | **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 or guardian | | \_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_  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 | |
| **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 |  |