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| **GP MENTAL HEALTH Treatment PLAN** – Version for children |
| ***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** |  | **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** |  |
| **Was patient involved in discussion with GP about treatment plan?** | [ ]  Yes | [ ]  No |
| **Was parent/guardian involved in discussion with GP about patient’s treatment plan?** | [ ]  Yes | [ ]  No |
| **Was the parent considered for a mental health treatment plan?** | [ ]  Yes | [ ]  No |
| **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.** |  | **Healthcare Card No.** |  |
| **Parent/guardian details**  | **Has patient consented for this Treatment Plan to be released to parents/guardians?** |
| First parent/guardian: | Relationship: | Phone number 1:Phone number 2: | [ ]  YesWith the following restrictions: | [ ]  No |
| Second parent/guardian: | Relationship: | Phone number 1:Phone number 2: | [ ]  YesWith the following restrictions: | [ ]  No |
| **Emergency contact person details** | **Patient/parent/ guardian 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 |
| **Schooling (if applicable)** |
| **Current school level** |  | **Name of school/pre-school** |  |
| **Salient school factors**Consider:* Prior disruption to schooling
* Current frequency of school attendance
* Ability to start and finish homework
* Peer relationships
* Bullying
* Traumatic school community events
 |  |
| **Patient/guardian consent to discuss GPMHTP with the following members of school community:** |
|  | **Role** | **Name(s)** | **Phone** |
| [ ]  Yes | **Principal** |  |  |
| [ ]  Yes | **Assistant Principal(s)** |  |  |
| [ ]  Yes | **Teacher(s)** |  |  |
| [ ]  Yes | **School Counsellor(s)** |  |  |
| [ ]  Yes | **Other** |  |  |
| **SALIENT COMMUNICATION AND CULTURAL FACTORS** |
| **Language spoken at home** | [ ]  English | [ ]  Other: |
| **Interpreter required** | [ ]  No | [ ]  Yes, Comments: |
| **Country of birth** | [ ]  Australia | [ ]  Other: |
| **Other communication issues** |  |
| **Other cultural issues** |  |

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| **PATIENT ASSESSMENT – MENTAL HEALTH** |
| **Reasons for presenting**Consider:* What are the patient’s current mental health issues?
* Behavioural issues
* Requests and hopes
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| **History of current episode**Consider:* Symptom onset, duration, intensity, time course
 |  |
| **Implications of symptoms on child’s daily activities** |  |
| **Patient history**Consider: |  |
| * Mental health history
 |  |
| * Salient social history
 |  |
| * Salient medical/biological history
* ♀ - menarche, menstruation, pregnancy
 |  |
| * Salient developmental issues
 |  |
| **Family history of mental illness**Consider:* Family history of suicidal behaviour
* Genogram
 |  |
| **Current domestic and social circumstances**Consider:* Living arrangements
* Siblings
* Custodial arrangements
* Social relationships
* Engagement with peers
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| **Salient substance use issues**Consider:* Nicotine use
* Alcohol use
* Illicit substances
* Is patient willing to address the issues?
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| **Current medications**Consider:* Dosage, date of commencement, date of change in dosage
* Reason for the prescription
* Are there other practitioners involved in the prescription of medication?
* Are there issues with compliance or misuse?
 |  |
| **History of medication and other treatments for mental illness**Consider:* School counselling and other school interventions
* Past referrals
* Effectiveness of previous treatments
* Side-effects and complications associated with previous treatments
* Patient’s preference for medications
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| **Allergies** |  |
| **Relevant physical examination and other investigations** |  |
| **Results of relevant previous psychological and developmental testing** |  |
| **Other care plan**e.g. GP Management Plans and Team Care Arrangements; Wellness Recovery Action Plan | [ ]  Yes, Specify:  [ ]  No  |
| **Comments on Current Mental State Examination** |
| **Consider:*** Appearance, cognition, thought process, thought content, attention, memory, insight, behaviour, speech, mood and affect, perception, judgement, orientation.
 |  |
| **Risk assessment** **If high level of risk indicated, document actions taken in Treatment Plan below** Consider:* 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** |
|  |
| **Assessment/outcome tool used,** except where clinically inappropriate.* e.g., Strengths and Difficulties Questionnaire
* Note: K-10 is not validated for minors
 |  |
| **Date of assessment** |  |
| **Results** | [ ]  Copy of completed tool provided to referred practitioner |
| **Provisional diagnosis of mental health disorder**Consider conditions specified in the ICPC, including:* Anxiety co-morbid with Autism
* ADD/ADHD
* Conduct disorder
* Oppositional defiant disorder
* Mood disorder
* Separation anxiety
* Phobias
* Elective mutism
* Reactive attachment disorder
* Nonorganic enuresis and encopresis
* Eating disorder
* Adjustment disorder (e.g. grief/loss/ parental separation/trauma/medical condition)
* Depression
* Anxiety
* Unexplained somatic disorder
* Mental disorder not otherwise specified
 |  |
| **Case formulation**Consider:* Predisposing factors
* Precipitating factors
* Perpetuating factors
* Protective factors
 |  |
| **Other relevant information from carer/informants**Consider:* Specific concerns of carer/family
* Impact on carer/family
* Contextual information from members of patient’s community
* Other content from individuals other than the patient
 |  |
| **Any other comments** |  |

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| **PLAN** |
|  |  | **Actions** |
| **Identified issues/problems**Consider:* As presented by patient
* Developed during consultation
* Formulated by GP
 | **Goals**Consider:* Goals made in collaboration with patient
* What does the patient want to see as an outcome from this plan?
* Behavioural or symptomatic goals
* Wellbeing, function, occupation, relationships
* Any reference to special outcome measures
* Time frame
 | **Treatments & interventions**Consider:* psychological interventions
* face to face
* internet based

Program* [The Brave Program](https://brave4you.psy.uq.edu.au/) (anxiety only)

Websites* [Reach Out](http://au.reachout.com/)
* [BITE BACK](http://www.biteback.org.au/)
* [Eheadspace](https://www.eheadspace.org.au/)

Mobile Applications* [Smiling Mind](http://smilingmind.com.au/?gclid=CO3qj72N68YCFQaXvQod8HII8g)
* [Mind the Bump](http://www.mindthebump.org.au/?gclid=CMWjhduN68YCFVMAvAodIrkN1w)
* [Worry Time](http://au.reachout.com/reachout-worrytime-app?gclid=CKuXweiN68YCFVAIvAodZywM6w)
* [The Desk](https://www.thedesk.org.au/login?login)
* pharmacological interventions
* Key actions to be taken by patient and by guardians
* Support services to achieve patient goals
* Parent Management Training
* Role of GP
* Psycho-education
* Time frame
 | **Referrals**Consider:* Practitioner, service or agency—referred to whom and what for
* Specific referral request
* referral to internet mental health programs for education and/or specific

psychotherapy Program* [The Brave Program](https://brave4you.psy.uq.edu.au/) (anxiety only)

Websites* [Reach Out](http://au.reachout.com/)
* [BITE BACK](http://www.biteback.org.au/)
* [Eheadspace](https://www.eheadspace.org.au/)

Mobile Applications* [Smiling Mind](http://smilingmind.com.au/?gclid=CO3qj72N68YCFQaXvQod8HII8g)
* [Mind the Bump](http://www.mindthebump.org.au/?gclid=CMWjhduN68YCFVMAvAodIrkN1w)
* [Worry Time](http://au.reachout.com/reachout-worrytime-app?gclid=CKuXweiN68YCFVAIvAodZywM6w)
* [The Desk](https://www.thedesk.org.au/login?login)
* Opinion, planning, treatment
* Case conferences
* Time frame
 | **Any role of carer/support person(s)**Consider:* Identified role or task(s), e.g. monitoring, intervention, support
* Discussed, agreed, negotiated with carer?
* Any necessary supports for carer
* Time frame
 |
| **Issue 1:** |  |  |  |  |
| **Issue 2:** |  |  |  |  |
| **Issue 3:** |  |  |  |  |
| **Intervention/relapse prevention plan** (if appropriate at this stage)Consider:* Identify warning signs from past experiences
* Note arrangements to intervene in case of relapse or crisis
* Other support services currently in place
* Note any past effective strategies
 |  |
| **Psycho-education provided if not already addressed in “treatments and interventions” above?** | [ ]  Yes[ ]  No |
| **Plan added to the patient’s records?** | [ ]  Yes[ ]  No |

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| **Other healthcare providers and service providers involved in patient’s care**(e.g. 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 s/he has:[ ]  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 or guardian)*, agree to information about my/my charge’s health being recorded in my medical file and being shared between the General Practitioner and other health care providers involved in my/his/her care, as nominated above, to assist in the management of my/my charge’s health care. I understand that I must inform my GP if I wish to change the nominated people involved in my/my charge’s care. I understand that as part of my/my charge’s care under this Mental Health Treatment plan, I/he/she 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 or guardian)* | \_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_*(Date)* |
| I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, have discussed the plan and referral(s) with the patient.*(Full name of GP)* |
| \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*(Signature of GP)* | \_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_*(Date)* |

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| **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**Consider:* Progress on goals and actions
* Have identified actions been initiated and followed through? e.g. referrals, appointments, attendance
* Checking, reinforcing and expanding education
* Communication
* Where appropriate, communication received from referred practitioners
* Modification of treatment plan if required
 |  |
| **Intervention/relapse prevention plan** (if appropriate)Consider:* Identify warning signs from past experiences
* Note arrangements to intervene in case of relapse or crisis
* Other support services currently in place
* Note any past effective strategies
 |  |