

**GP Mental Health Treatment Plan**

**STEP 1: Assessment**

<b>Patient Details</b>	<b>Patient Name</b>		<b>Medical Records number</b>	
	<b>Address</b>			
	<b>Phone</b>		<b>D.O.B</b>	
	<b>Gender</b>	<input type="checkbox"/> Male <input type="checkbox"/> Female		
	<b>Aboriginal/Torres Strait Islander?</b>	<input type="checkbox"/> Aboriginal <input type="checkbox"/> Torres Strait Islander <input type="checkbox"/> Neither <input type="checkbox"/> Unknown		
<b>GP Details</b>	<b>General Practitioner</b>		<b>Provider Number</b>	
	<b>Address</b>			
	<b>Phone</b>		<b>Fax</b>	
<b>Referral Details</b>	<b>Allied Mental Health Provider involved in care</b>		<b>Phone</b>	
	<b>Other Care Plan e.g. GPMP/TCA</b>			
	<b>ATAPS Referral ID</b>		<b>ATAPS Referral Expiry date</b>	
<b>Presenting Symptoms or Complaints</b>				
<b>History of Presenting Problems</b>		<b>Past Medical History:</b>		
		<b>Past Mental Health History:</b>		
		<b>Social History:</b>		
		<b>Family History:</b>		
<b>Medications:</b>				
<b>Allergies:</b>				
<b>Mental State Examination:</b>	<b>Appearance:</b>	<input type="checkbox"/> Normal	<input type="checkbox"/> Other:	
	<b>Behaviour:</b>	<input type="checkbox"/> Normal	<input type="checkbox"/> Other:	
	<b>Affect/Mood:</b>	<input type="checkbox"/> Normal	<input type="checkbox"/> Other:	
	<b>Speech:</b>	<input type="checkbox"/> Normal	<input type="checkbox"/> Other:	
	<b>Thought Form:</b>	<input type="checkbox"/> Normal	<input type="checkbox"/> Other:	
	<b>Thought Content:</b>	<input type="checkbox"/> Normal	<input type="checkbox"/> Other:	
	<b>Perceptual Disturbance:</b>	<input type="checkbox"/> Normal	<input type="checkbox"/> Other:	
	<b>Cognition:</b>	<input type="checkbox"/> Normal	<input type="checkbox"/> Other:	
	<b>Judgement:</b>	<input type="checkbox"/> Normal	<input type="checkbox"/> Other:	
	<b>Insight:</b>	<input type="checkbox"/> Normal	<input type="checkbox"/> Other:	
<b>Risk to Self</b>	Suicide	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unsure	Self Harm	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unsure
<b>Risk to Others</b>	Risk to Others:	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unsure		
<b>Outcome Tool Used</b>	<input type="checkbox"/> DASS 21 <input type="checkbox"/> K10 <input type="checkbox"/> Other:		<b>Score:</b>	
<b>Diagnosis/Formulation</b>				

## GP Mental Health Treatment Plan

### STEP 2: Care Plan

Patient Needs/Main Issues	Goals: Record the mental health goals agreed to by the patient and GP and any actions the patient will need to take	Treatments: Treatments, actions and support services to achieve patient goals	Referrals: Note: Referrals to be provided by GP, as required. The need for second group of sessions to be reviewed after the initial sessions
		<p><b>Initial action plan to be considered:</b> Taking into account the issues that you and the patient have identified, summarise the initial action suggested (tick appropriate box)</p> <p><input type="checkbox"/> Diagnostic Assessment</p> <p><input type="checkbox"/> Psycho-education</p> <p><input type="checkbox"/> Interpersonal Therapy</p> <p><input type="checkbox"/> Cognitive Behaviour Therapy (CBT)</p> <p style="margin-left: 20px;"><input type="checkbox"/> Behavioural interventions</p> <p style="margin-left: 20px;"><input type="checkbox"/> Cognitive interventions</p> <p style="margin-left: 20px;"><input type="checkbox"/> Relaxation strategies</p> <p style="margin-left: 20px;"><input type="checkbox"/> Skills training</p> <p style="margin-left: 20px;"><input type="checkbox"/> Other CBT interventions</p> <p><input type="checkbox"/> Other (incl drug therapy) pls specify: _____</p>	<p><b>Referred to:</b> _____.</p> <p><b>Contact details of allied mental health provider:</b> Phone: Fax:</p>
<b>Crisis/Relapse</b> Note the arrangements for crisis intervention and/or relapse prevention			
<b>Plan added to the Patient's Records</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<b>Copy (or parts) of the plan offered to other Providers?</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No
<p><b>Completing the plan:</b> On completion of the plan, the GP is to record that s/he has discussed with the patient:</p> <p style="margin-left: 40px;">- the assessment <span style="float: right;"><input type="checkbox"/> Yes <input type="checkbox"/> No</span></p> <p style="margin-left: 40px;">- all aspects of the plan and the agreed date for review <span style="float: right;"><input type="checkbox"/> Yes <input type="checkbox"/> No</span></p> <p style="margin-left: 40px;">- offered a copy of the plan to the patient and/or their carer (if agreed by the patient) <span style="float: right;"><input type="checkbox"/> Yes <input type="checkbox"/> No</span></p>			
<b>Date plan completed:</b>	<b>Review date:</b> (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**  
**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  No If yes, who? \_\_\_\_\_.
  
- **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 SESDGP 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)