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|  **Patient wellbeing assessment** **and recovery plan** **– Children and adolescents**  |
| **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.***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 |
| **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 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/preschool** |  |
| **Salient school factors**Consider asking:* Has there been any prior disruption to schooling?
* What is the current frequency of school attendance?
* What is the patient’s ability to start and finish homework?
* How are the patient’s peer relationships?
* Has the patient experienced any bullying?
* Has the patient experienced any 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 factors** |  |
| **Other relevant cultural issues** |  |

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| **Patient wellbeing assessment** |
| **Reasons for presenting**Consider asking:* What are the patient’s current mental health issues?
* What requests and hopes does the patient have?
 |  |
| **History of current episode**Consider asking about:* Symptom onset, duration, intensity, time course
 |  |
| **Implications of symptoms on child/adolescent’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 asking about:* Family history of suicidal behaviour
* Genogram
 |  |
| **Current domestic and social circumstances**Consider asking about:* Living arrangements
* Siblings
* Custodial arrangements
* Social relationships

Engagement with peers |  |
| **Salient substance use issues**Consider asking about:* Nicotine use
* Alcohol use
* Illicit substances
* Is patient willing to address the issues?
 |  |
| **Current medications**Consider asking about:* 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 asking about:* 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
 |  |
| **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 strengths and positive dispositions** |
| Consider asking about:* Abilities, talents and interests
* Competencies and accomplishments
* Previous self-help strategies used and those available in the family support network
* Service system and the community at large
 |  |
| **Comments on current mental state examination** |
| Consider:* Appearance, cognition, thought process, thought content, attention, memory, insight, behaviour, speech, mood and affect, perception, judgement, orientation
 |  |
| **Trauma-informed care and practice (TICP) assessment** |
| **Consider possible influence of trauma**Trauma can be defined as:* Exposure to death
* Threatened death
* Actual serious injury
* Threatened serious injury
* Actual sexual violence

Threatened sexual violence |  |
| **Risk assessment –** **If high level of risk indicated, document actions taken in 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** |
|  |
| **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 (eg grief/loss/ parental separation/trauma/medical condition)
* Depression
* Anxiety
* Unexplained somatic disorder
* Mental disorder not otherwise specified
 |  |
| **Case formulation**Consider asking about:* Predisposing factors
* Precipitating factors
* Perpetuating factors
* Protective factors
 |  |
| **Other relevant information from carer/informants**Consider asking about:* 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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| **Personal recovery 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?
* Wellbeing, function, occupation, relationships
* Any reference to special outcome measures
* Time frame
 | **Treatments & interventions**Consider:* Suggested psychological interventions
* Medications
* Key actions to be taken by patient
* 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 what for
* 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)
 | **Any role of carer/support person(s)**Consider:* Identified role or task/s (eg monitoring, intervention, support)
* Discussed, agreed, and 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 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
 |  |
| **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****(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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| **Record of consent** |
| I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_[name of patient or parent/guardian as applicable], agree to information about my/my charge’s health being recorded in my medical file and being shared between the GP and other healthcare providers involved in my/his/her care, as nominated above, to assist in the management of my/my charge’s healthcare. 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 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 servicesDear DrI 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 [ ] NoSpecific 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** Consider:* Progress on goals and actions
* Identified actions have been initiated and followed through (e.g. referrals, appointments, attendance)
* Checking, reinforcing and expanding education
* Communication between the GP and patient
* Where appropriate, communication received from referred practitioners
* Modification of treatment plan if required
 |  |
| **Intervention/relapse prevention plan** (if appropriate)Consider:* Warning signs from past experiences
* Arrangements to intervene in case of relapse or crisis
* Other support services currently in place
* Any past effective strategies
 |  |