GP Mental Health Treatment Plan

MBS Item Number 2715 for Mental Health Skills Trained GP

MBS Item Number 2700 for Non-Mental Health Skills Trained GP

NOTE: This referral is NOT for emergency/crisis intervention

Faxback to ATAPS confidential referral line on 41510794

Client ID (OFFICE USE ONLY)	**Referral Expires** (OFFICE USE ONLY)	**NB:** Sessions for each referral need to be completed within 4 months of referral date	
GP Name, Practice and Postal Address		**GP Contact Numbers**	Ph: Fax:
Client Name & Title		**Client DoB**	
Client Address		**Client Phone No.**	Home: Work: Mobile:
Gender		**Medicare Number**	
AHP or RN currently involved in client care		**Carer and/or emergency contact(s)**	
Does the person speak a language other than English at home; ie Culturally and Linguistically Diverse (CALD)	☐ No, English only ☐ Yes, please specify: _____	**Interpreter Required?**	☐ Yes ☐ No
Is the person of Aboriginal or Torres Strait Islander origin?	☐ No ☐ Yes, Aboriginal ☐ Unknown ☐ Yes, TSI		
Does the person live on their own?	☐ Yes ☐ No		
Is the person a low income earner?	☐ Yes ☐ No		
Does the person have a Health Care Card? **Number and Expiry Date**	☐ Yes ☐ No _____		
Highest level of education completed?	☐ Primary or below ☐ Between Primary and Year 10 ☐ Secondary, Year 10 ☐ Secondary, Year 11 ☐ Secondary, Year 12 ☐ Tertiary		
Prior mental health care?	☐ Yes ☐ No		
Perinatal History (Attach EPDS)	☐ Antenatal ☐ Postnatal (Infant must be <12 months)		
PRESENTING ISSUE(S) What are the client's current mental health issues			
Mental Health Strategies **ICD-10 primary care diagnosis (multiple responses permitted)**	☐ F1- Alcohol and Drug Use ☐ F5- unexplained somatic complaints ☐ F2- Psychotic disorders ☐ Unknown ☐ F3- Depression ☐ Other, please specify _____ ☐ F4- Anxiety		

Which psychological strategies/CBT interventions are required?	**Strategies Required:** ☐ Diagnostic Assessment ☐ Interpersonal Therapy ☐ Psycho Education ☐ Other, please specify _____ **CBT:** ☐ Cognitive interventions ☐ Behavioural interventions ☐ Relaxation Strategies ☐ Skills training
Please indicate what psychotropic medication the person is receiving	☐ Mood stabilisers ☐ Antidepressants ☐ None ☐ Phenzothiazines & Tranquilisers (Antipsychotics) ☐ Benzodiazepines and Anxiolytics
MEDICATIONS	
RISKS AND CO-MORBIDITIES Note any associated risks and co-morbidities including suicidal tendencies and risks to others	
CLIENT HISTORY Record relevant biological, psychological and social history	***FAMILY HISTORY:*** ***SOCIAL HISTORY:***
SUBSTANCE MISUSE Please specify "Other" & "Prescription Medications"	☐ Prescription Medications _____ ☐ Other recreational drugs _____

RESULTS OF MENTAL STATE EXAM	**Normal**	**Other**	**Comments**
Appearance and General Behaviour			
Mood (Depressed/Labile)			
Thinking (Content/Rate/Disturbances)			
Affect (Flattened/blunted)			
Perception (Hallucinations etc.)			
Sleep (Initial Insomnia/Early Morning Wakening)			
Cognition (Level of Consciousness/Delirium/ Intelligence)			
Appetite (Disturbed Eating Patterns)			
Attention/Concentration			
Motivation/Energy			
Memory (Short and Long Term)			
Judgement (Ability to make rational decisions)			
Insight (Understanding/knowledge of problem)			
Anxiety Symptoms (Physical & Emotional)			
Orientation (Time/Place/Person)			
Speech (Volume/Rate/Control)			

ATTACH A COPY OF COMPLETED OUTCOME TOOL USED e.g., K10, DASS21, EPDS etc.

GOALS Record the mental health goals agreed to by the client and GP and any actions the client will need to take	
TREATMENTS Treatments, actions and support services to achieve client goals	
REFERRALS Note: Referrals to be provided by GP as required, in up to two groups of six sessions. The need for the second group of sessions to be reviewed after the initial six sessions.	Please tick one ☐ Coastal Life Therapies - Bundaberg ☐ Desley Fraser & Associates – Maryborough ☐ Fraser Coast Psychology – Hervey Bay ☐ headspace - Hervey Bay ☐ Stepping Stones Child Psychologist – Hervey Bay
CRISIS/RELAPSE If required, note the arrangements for crisis intervention and/or relapse prevention	

Support person contact details must be completed (ie; next of kin, friend, etc.)			
Name		**Relationship**	
Contact Details			

DATE PLAN COMPLETED	
REVIEW DATE	
REVIEW COMMENTS (Progress on actions and tasks)	
OUTCOME TOOL RESULTS (after review)	

Client Consent

I give my consent for this referral to be forwarded to RHealth Limited for the coordination of this service on my behalf. I understand that a Health Practitioner allocated by RHealth Limited will contact me on the telephone number/s given on the referral. I understand that I may be required to provide de-identified feedback on services received as part of my participation in the program by completing a Client Perception of Care feedback Questionnaire.

Client Signature:		Date:	
GP Signature:		Date:	

Referral MUST be signed by both the referrer and client
Unsigned referrals will NOT be accepted