

GP MENTAL HEALTH TREATMENT PLAN – MINIMAL REQUIREMENTS

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 ☐ 27011 ☒ 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.

Here is a printable version of the E-MENTAL HEALTH PATIENT INFORMATION BROCHURE for your patients

CONTACT AND DEMOGRAPHIC DETAILS

GP name	Dr Haythem Amir	GP phone	0245781267
GP practice name	Hks Medical Centre	GP fax	
GP address	304 Windsor Street Richmond 2573	Provider number	438716DH
Patient surname	Smith	Date of birth (dd/mm/yy)	22/11/1989
Patient first name(s)	Luke	Preferred name	Luke
Gender	Male <input checked="" type="checkbox"/> Self-identified gender: male		
Patient address	13/147 March St Richmond 2753	Patient phone Can leave message? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Medicare No.	2706115793	Healthcare Card/Pension No.	
Emergency contact person details	Mr Lynda Smith Mother 0425226307	Patient consent for healthcare team to contact emergency contacts?	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No

PATIENT ASSESSMENT – MENTAL HEALTH	
<u>Reasons for presenting</u>	de
<u>Present history</u> Record relevant <u>medical/</u> <u>psychological, mental health/</u> <u>psychological, and social history</u>	
<u>Current mental state</u> <u>Observation</u>	depression
<u>Risk assessment</u> any identified risks, including of self-harm and harm to others	
<u>Assessment/outcome tool used</u> <u>Results</u> not where clinically appropriate	
<u>Provisional diagnosis of mental</u> <u>health disorder</u>	
<u>Formulation</u>	

PLAN			
Identified issues/problems	Goals Record goals made in collaboration with patient	Treatments & interventions Any actions and <u>support services</u> to achieve patient goals <u>Actions to be taken by patient</u> Consider: <ul style="list-style-type: none"> • psychological and/or pharmacological options • face to face options • internet-based options • 	Referrals <u>Or appropriate support services</u> Consider: <ul style="list-style-type: none"> • referral to internet mental health programs for education and/or specific psychotherapy •
seperation anxiety missing his cild depression	reduce the depression and anxiety symptoms	psychologist concider medications	psychologist
Intervention/relapse prevention plan If appropriate at this stage, note arrangements to intervene in case of relapse or crisis,			
Psycho-education provided?		<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
Plan added to the patient's records?		<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
Completing the plan On completion of the plan, the GP may record (tick boxes below) that s/he has: <input checked="" type="checkbox"/> discussed the assessment with the patient <input type="checkbox"/> 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 19/03/2024

RECORD OF PATIENT CONSENT				
<p>I, _____ (name of patient), agree to information about my health being recorded in my medical file and being shared between the General Practitioner and other health care providers involved in my care, as nominated above, to assist in the management of my health care. I understand that I must inform my GP if I wish to change the nominated people involved in my care.</p> <p>I understand that as part of my care under this Mental Health Treatment plan, I should attend the GP for a review appointment at least 4 weeks after but within 6 months after the plan has been developed.</p> <p>I consent to the release of the following information to the following carer/support and emergency contact persons:</p>				
Name	Assessment		Treatment Plan	
	Yes	No	Yes	No
	<input type="checkbox"/> with the following limitations:	<input type="checkbox"/>	<input type="checkbox"/> with the following limitations:	<input type="checkbox"/>
	<input type="checkbox"/> with the following limitations:	<input type="checkbox"/>	<input type="checkbox"/> with the following limitations:	<input type="checkbox"/>

REVIEW**MBS ITEM NUMBER:** ☐ 2712 ☐ 2719**Date for review with GP**

(initial review 4 weeks to 6 months after completion of plan)

26/07/2024

Assessment/outcome tool results on review, except where clinically inappropriate**Comments**Review of patient's progress against goals; checking, re-enforcing 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



HKS Medical Centre

304 Windsor st, Richmond NSW 2753

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19/03/2024

Dr Michelle Hookham

Re/Mr Luke Smith
13/147 March St
Richmond 2753
M/C No.2706115793

0427843775

Dear Doctor

I would like to refer Mr Luke Smith, DOB 22/11/1989 who is suffering from major depression and sever anxiety .

I am looking for your urgent assessment and advices about his on going management.

No regular medications.

Past medical history:
Not recorded.

Allergy and reaction
Nil known.

If I can be of any further assistance in the care of this patient or any other patient,