

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 Laura Chapman	GP phone	0398287570
GP practice name	CLARITY MEDICAL GROUP	GP fax	0398287571
GP address	338 Dandenong Rd St Kilda East 3183	Provider number	4209537T
Patient surname	Wade	Date of birth (dd/mm/yy)	31/01/1974
Patient first name(s)	Sharon	Preferred name	Sharon
Gender	Female <input type="checkbox"/> Self-identified gender:		
Patient address	10 Fieldlark Court Carrum Downs 3201	Patient phone Can leave message? <input type="checkbox"/> Yes <input type="checkbox"/> No	0416779237
Medicare No.	3282486498	Healthcare Card/Pension No.	
Emergency contact person details	Ben Cox Partner 0403919303	Patient consent for healthcare team to contact emergency contacts?	<input type="checkbox"/> Yes <input type="checkbox"/> No

PATIENT ASSESSMENT – MENTAL HEALTH

<u>Reasons for presenting</u>	anxiety about to begin benzo taper needs more scaffolding in place to support this birth trauma perimenopause
<u>Patient history</u> Record relevant <u>medical/</u> <u>biological</u> , <u>mental health/</u> <u>psychological</u> , and <u>social history</u>	Hypertension Anxiety Gastritis Hiatus hernia Hypercholesterolaemia
<u>Results of mental state examination</u>	anxious, good rapport, well kempt
<u>Risk assessment</u> Note any identified risks, including risks of self-harm and harm to others	low risk
<u>Assessment/outcome tool used and results</u> , except where clinically inappropriate	DASS21 Assessment Depression scored 22 (Severe) Anxiety scored 24 (Extremely Severe) Stress scored 34 (Extremely Severe)
<u>Provisional diagnosis of mental health disorder</u>	anxiety, depression, opiate dependance
<u>Case formulation</u>	mood disorder and long term benzo use with assoc intermitant panic and hypertension

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 MoodGYM https://moodgym.anu.edu.au/welcome 	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
	reduce suffering be happier improve family life unpack medical trauma		
<u>Intervention/relapse prevention plan</u> If appropriate at this stage, note arrangements to intervene in case of relapse or crisis,			
<u>Psycho-education</u> 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		
<u>Completing the plan</u> On completion of the plan, the GP may record (tick boxes below) that s/he has: <ul style="list-style-type: none"> <input 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

RECORD OF PATIENT CONSENT				
<p>I, _____ (<i>name of patient</i>), 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"/> with the following limitations:	<input type="checkbox"/>
--	--	--	--------------------------


(Signature of patient or guardian)

_____/_____/_____

(Date)

I, Laura Chapman, have discussed the plan and referral(s) with the patient.

(Full name of GP)



(Signature of GP)

5/7/25

_____/_____/_____

(Date)

REVIEW	
MBS ITEM NUMBER: <input type="checkbox"/> 2712 <input type="checkbox"/> 2719	
Date for review with GP (initial review 4 weeks to 6 months after completion of plan)	
Assessment/outcome tool results on review , except where clinically inappropriate	
Comments <u>Review of patient's progress against goals; checking, re-enforcing and expanding education; modification of treatment plan if required</u>	
Plan for crisis intervention and/or for relapse prevention , if appropriate and if not previously provided	