

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	Lamborn	Date of birth (dd/mm/yy)	14/12/1992
Patient first name(s)	Melissa	Preferred name	Mel
Gender	Female ☐ Self-identified gender:		
Patient address	252 Alma Road Caulfield North 3161	Patient phone Can leave message? ☒ Yes ☐ No	
Medicare No.	3573232361	Healthcare Card/Pension No.	
Emergency contact person details	Matthew O'Shes Partner 0422236391	Patient consent for healthcare team to contact emergency contacts?	☒ Yes ☐ No

PATIENT ASSESSMENT – MENTAL HEALTH

<u>Reasons for presenting</u>	PPP, fatigue Pain physician input not as helpful as has been in past
<u>Patient history</u> Record relevant <u>medical/</u> <u>biological, mental health/</u> <u>psychological, and social history</u>	26/10/2024 Endometriosis Bilateral sacral block
<u>Results of mental state examination</u>	low, 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 28 (Extremely Severe) Anxiety scored 18 (Severe) Stress scored 32 (Severe)
<u>Provisional diagnosis of mental health disorder</u>	anxiety and depression
<u>Case formulation</u>	Past few years worsening pain and fatigue, reduced wellbeing, unable to do the things she wants to

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: - 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: referral to internet mental health programs for education and/or specific psychotherapy
pain	help with changing headspace- flat, spiralling downhill	psychologist	Ana
<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?	☒ Yes ☐ No		
Plan added to the patient's records?	☒ Yes ☐ No		
<u>Completing the plan</u> On completion of the plan, the GP may record (tick boxes below) that s/he has: ☐ 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 09/06/2025

RECORD OF PATIENT CONSENT				
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. 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. 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. (Signature of GP) / / (Date)			

REVIEW	
MBS ITEM NUMBER: ☒ 2712 ☐ 2719	
Date for review with GP (initial review 4 weeks to 6 months after completion of plan)	5/1//25
Assessment/outcome tool results on review , except where clinically inappropriate	telehealth K10 29, 3 weeks ago was 35, how often do you fell depressed- 'all of the time'
Comments <u>Review of patient's progress against goals; checking, re-enforcing and expanding education; modification of treatment plan if required</u>	feels like gradually moving in the right direction sleeping better- routined can feel anxious or low and can lock in and ruminate
Plan for crisis intervention and/or for relapse prevention , if appropriate and if not previously provided	ed or lifeline in crisis