

# Mental Health Treatment Plan

Item 2715 / 2717 / 2701 / 2700



Please note the following details **must** be provided before the Mental Health Treatment Plan will be accepted: Patient details, GP details, Problem/Diagnosis, Risk Assessment, Patient Consent and GP signature.

## Step 1: Patient assessment

### Patient Details (must complete)

|   |  |                |   |              |
|---|--|----------------|---|--------------|
| Name:   |  |                | Outcome Tool used:  | Results:     |
|   |  |                | <input type="checkbox"/> K-10+ / DASS-21 <input type="checkbox"/>   |              |
| Address:  |  |                |   |              |
| Phone:  |  | D.O.B.:        |   |              |
| Gender:   |  | Referral date: |   | Medicare No. |
| Does the patient identify as Aboriginal or Torres Strait Islander?      |  |                | <input type="checkbox"/> Aboriginal<br><input type="checkbox"/> Torres Strait Islander<br><input type="checkbox"/> Both<br><input type="checkbox"/> Neither |              |
| Is the patient from a Culturally and Linguistically Diverse background? |  |                | <input type="checkbox"/> Yes <input type="checkbox"/> No  |              |
| Does the patient or relative have a serious illness?                    |  |                | <input type="checkbox"/> Yes <input type="checkbox"/> No  |              |
| If yes, is the mental health concern related to the serious illness?    |  |                | <input type="checkbox"/> Yes <input type="checkbox"/> No  |              |

### GP details (must complete)

|          |  |          |  |
|----------|--|----------|--|
| Name:    |  | Surgery: |  |
| Address: |  | Phone:   |  |

### Problem/diagnosis (must complete)

| Number 1 | Number 2 | Number 3 |
|----------|----------|----------|
|          |          |          |

### Risk assessment (must complete)

|   |  |                             |
|---|--|-----------------------------|
| Has current suicidal thoughts                             | <input type="checkbox"/> Yes (If yes, please contact Sonder) | <input type="checkbox"/> No |
| Has a current plan to end their life                      | <input type="checkbox"/> Yes (If yes, please contact Sonder) | <input type="checkbox"/> No |
| Has attempted suicide in the last 6 months                | <input type="checkbox"/> Yes (If yes, please contact Sonder) | <input type="checkbox"/> No |
| Is at risk of harming others (due to violence/aggression) | <input type="checkbox"/> Yes (If yes, please contact Sonder) | <input type="checkbox"/> No |

Other comments:

### Medications

### Allergies

|  |  |
|--|--|
|  |  |
|--|--|

### Relevant physical and mental examination

|  |
|--|
|  |
|--|

### Patient history

*Include relevant biological, psychological and social history, including any family history of mental disorders and any relevant substance abuse or physical health problems.*

|  |
|--|
|  |
|--|

### Patient demographics

**Has the patient ever received specialist mental health care?**  Yes  No

**Language/s spoken at home:**  English  Italian  Greek  Cantonese  Mandarin  
 Arabic  Vietnamese  Other: \_\_\_\_\_

**How well does the patient speak English:**  Very well  Well  Not well  Not at all

**Does the patient live alone:**  Yes  No If no, with whom: \_\_\_\_\_

**Is the accommodation:**  Stable  Unstable  Unknown

**Country of birth:** \_\_\_\_\_ **Nationality:** \_\_\_\_\_

**Highest education level completed:**  No Education/Pre-Primary  Primary  Junior Secondary  
 Senior Secondary  Certificate/Diploma Level  Bachelor Degree  Post-graduate qualifications

**Employment Status:**  Student  Unemployed  Employed full time  Employed part time  
 Home/Caring Duties  Other

**Pension or Health Card Status:**  Aged  Disability  Repatriation  Unemployment Benefit  
 Sickness Benefit  Other

**Marital Status:**  Single  Separated  Married  Divorced  De facto  Widowed

**Psychosocial assessment** (e.g. childhood, substance abuse, relationship history, coping with previous stressors)

Does the patient have any dependents:  Yes  No If yes, please tick:  Spouse  Children  Other

**Mental Status Examination:**

|  |   |
|--|---|
| <b>Appearance and general behaviour</b><br><input type="checkbox"/> Normal <input type="checkbox"/> Other:                         | <b>Mood</b> (depressed/labile)<br><input type="checkbox"/> Normal <input type="checkbox"/> Other:                         |
| <b>Thinking</b> (content/rate/disturbances)<br><input type="checkbox"/> Normal <input type="checkbox"/> Other:                     | <b>Affect</b> (flat/blunted)<br><input type="checkbox"/> Normal <input type="checkbox"/> Other:                           |
| <b>Perception</b> (hallucinations etc.)<br><input type="checkbox"/> Normal <input type="checkbox"/> Other:                         | <b>Sleep</b> (initial insomnia/early morning wakening)<br><input type="checkbox"/> Normal <input type="checkbox"/> Other: |
| <b>Cognition</b> (level of consciousness/delirium/intelligence)<br><input type="checkbox"/> Normal <input type="checkbox"/> Other: | <b>Appetite</b> (disturbed eating patterns)<br><input type="checkbox"/> Normal <input type="checkbox"/> Other:            |
| <b>Attention/Concentration</b><br><input type="checkbox"/> Normal <input type="checkbox"/> Other:                                  | <b>Motivation/Energy</b><br><input type="checkbox"/> Normal <input type="checkbox"/> Other:                               |
| <b>Memory</b> (short and long term)<br><input type="checkbox"/> Normal <input type="checkbox"/> Other:                             | <b>Judgement</b> (ability to make rational decisions)<br><input type="checkbox"/> Normal <input type="checkbox"/> Other:  |
| <b>Insight</b><br><input type="checkbox"/> Normal <input type="checkbox"/> Other:  | <b>Anxiety Symptoms</b> (physical and emotional)<br><input type="checkbox"/> Normal <input type="checkbox"/> Other:       |
| <b>Orientation</b> (time/place/person)<br><input type="checkbox"/> Normal <input type="checkbox"/> Other:                          | <b>Speech</b> (volume/rate/content)<br><input type="checkbox"/> Normal <input type="checkbox"/> Other:                    |

**Other Mental Health Professionals involved in patient care:**

| Name/Profession | Contact Details |
|-----------------|-----------------|
|                 |                 |
|                 |                 |

**Step 2: Mental Health Care Plan**

**Key family contact/support details/phone:**

**Emergency care/relapse prevention:**

**Initial action plan:**

| GOAL | TREATMENT | REFERRALS |
|------|-----------|-----------|
|      |           |           |

MHTP Review date:  Copy of Mental Health Treatment Plan given to patient?  Yes / No

**Patient consent to release information (must complete)**

I, \_\_\_\_\_ (**patient** name - please print clearly) understand that the aim of this referral to Sonder is for the provision of therapeutic sessions. This process involves an assessment and the development of a therapeutic plan for future sessions. I agree to be a part of the process with the knowledge that:

- My medical history will be shared with the GP and Clinician of the service chosen/and personnel of the chosen service where relevant;
- The information collected is private and will be kept confidential unless agreed upon by all parties to be shared;
- My GP has explained to me the reasons for seeking counselling/therapeutic input;
- No medicolegal reports will be provided;
- I understand that my treatment will be monitored and communicated between my treatment team and reviewed prior to the 6<sup>th</sup> session of therapy; and
- All personal information gathered will remain confidential and secure with my treating team and within the shared clinical management system hosted by funding bodies the Adelaide Primary Health Network and Country SA Primary Health Network.

**Patient signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

*For patients under 16 years:*

**Parent/guardian name:** \_\_\_\_\_ **Parent/guardian signature:** \_\_\_\_\_

I (GP named above) have discussed the proposed referral(s) with the patient and am satisfied that the client understands the proposed uses and disclosures and has provided their informed consent to these.

**GP signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Please fax completed referral form to the Central Referral Unit on 1300 580 249.**