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: ☐ K-10+ / DASS-21 ☐	Results:
Address:			
Phone:		D.O.B.:	
Gender:		Referral date:	Medicare No.

Does the patient identify as Aboriginal or Torres Strait Islander?	◯ Aboriginal ◯ Torres Strait Islander ◯ Both ◯ Neither
Is the patient from a Culturally and Linguistically Diverse background?	◯ Yes ◯ No
Does the patient or relative have a serious illness?	◯ Yes ◯ No
If yes, is the mental health concern related to the serious illness?	◯ Yes ◯ No

GP details *(must complete)*

Name:		Surgery:	
Address:		Ph + fax:	

Problem/diagnosis *(must complete)*

Number 1	*Number 2*	*Number 3*
Please choose one	Please choose one	Please choose one

Risk assessment *(must complete)*

Has current suicidal thoughts	◯ Yes (If yes, please contact Sonder) ◯ No
Has a current plan to end their life	◯ Yes (If yes, please contact Sonder) ◯ No
Has attempted suicide in the last 6 months	◯ Yes (If yes, please contact Sonder) ◯ No
Is at risk of harming others (due to violence/aggression)	◯ Yes (If yes, please contact Sonder) ◯ 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:	
Appearance and general behaviour ◯ Normal ◯ Other:	**Mood** (depressed/labile) ◯ Normal ◯ Other:
Thinking (content/rate/disturbances) ◯ Normal ◯ Other:	**Affect** (flat/blunted) ◯ Normal ◯ Other:
Perception (hallucinations etc.) ◯ Normal ◯ Other:	**Sleep** (initial insomnia/early morning wakening) ◯ Normal ◯ Other:
Cognition (level of consciousness/delirium/intelligence) ◯ Normal ◯ Other:	**Appetite** (disturbed eating patterns) ◯ Normal ◯ Other:
Attention/Concentration ◯ Normal ◯ Other:	**Motivation/Energy** ◯ Normal ◯ Other:
Memory (short and long term) ◯ Normal ◯ Other:	**Judgement** (ability to make rational decisions) ◯ Normal ◯ Other:
Insight ◯ Normal ◯ Other:	**Anxiety Symptoms** (physical and emotional) ◯ Normal ◯ Other:
Orientation (time/place/person) ◯ Normal ◯ Other:	**Speech** (volume/rate/content) ◯ Normal ◯ 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 6th 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:** _____

If the person being referred lives in the Adelaide metro area, please fax your referral to the Adelaide PHN Central Referral Unit on 1300 580 249.

If the person being referred lives in the Gawler/Barossa region, please fax your referral directly to Sonder on (08) 8252 9433.