GP MENTAL HEALTH TREATMENT PLAN – VERSION FOR CHILDREN

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 ☐ 2701 ☐ 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.***

CONTACT AND DEMOGRAPHIC DETAILS

GP name		**GP phone**	
GP practice name		**GP fax**	
GP address		**Provider number**	
Relationship	**This person has been my patient since**		
	and/or		
	This person has been a patient at this practice since		
Was patient involved in discussion with GP about treatment plan?		☐ Yes	☐ No
Was parent/guardian involved in discussion with GP about patient's treatment plan?		☐ Yes	☐ No
Patient surname		**Date of birth** (dd/mm/yy)	
Patient first name(s)		**Preferred name**	
Gender	☐ Female ☐ Male ☐ Self-identified gender:		
Patient address			
Patient phone	Preferred number: Can leave message? ☐ Yes ☐ No	Alternative number: Can leave message? ☐ Yes ☐ No	
Medicare No.		**Healthcare Card No.**	

Parent/guardian details			**Has patient consented for this Treatment Plan to be released to parents/guardians?**	
First parent/guardian:	Relationship:	Phone number 1: Phone number 2:	☐ Yes With the following restrictions:	☐ No
Second parent/guardian:	Relationship:	Phone number 1: Phone number 2:	☐ Yes With the following restrictions:	☐ No

Emergency contact person details			Patient/parent/ guardian consent for healthcare team to contact emergency contacts?	
First contact:	Relationship:	Phone number 1: Phone number 2:	☐ Yes	☐ No
Second contact:	Relationship:	Phone number 1: Phone number 2:	☐ Yes	☐ No

Schooling (if applicable)			
Current school level		**Name of school/pre-school**	
Salient school factors Consider: • Prior disruption to schooling • Current frequency of school attendance • Ability to start and finish homework • Peer relationships • Bullying • Traumatic school community events			

Patient/guardian consent to discuss GPMHTP with the following members of school community:

	Role	Name(s)	Phone
☐ Yes	**Principal**		
☐ Yes	**Assistant Principal(s)**		
☐ Yes	**Teacher(s)**		
☐ Yes	**School Counsellor(s)**		
☐ Yes	**Other**		

SALIENT COMMUNICATION AND CULTURAL FACTORS		
Language spoken at home	☐ English	☐ Other:
Interpreter required	☐ No	☐ Yes, Comments:
Country of birth	☐ Australia	☐ Other:
Other communication issues		
Other cultural issues		

PATIENT ASSESSMENT – MENTAL HEALTH	
Reasons for presenting Consider: • What are the patient's current mental health issues? • Behavioural issues • Requests and hopes	
History of current episode Consider: • Symptom onset, duration, intensity, time course	
Implications of symptoms on child's daily activities	
Patient history Consider:	
• Mental health history	
• Salient social history	
• Salient medical/biological history • ♀ - menarche, menstruation, pregnancy	
• Salient developmental issues	
Family history of mental illness Consider: • Family history of suicidal behaviour • Genogram	
Current domestic and social circumstances Consider: • Living arrangements • Siblings • Custodial arrangements • Social relationships • Engagement with peers	
Salient substance use issues Consider: • Nicotine use • Alcohol use • Illicit substances • Is patient willing to address the issues?	
Current medications Consider: • Dosage, date of commencement, date of change in dosage • Reason for the prescription • Are there other practitioners involved in the prescription of medication? • Are there issues with compliance or misuse?	

History of medication and other treatments for mental illness Consider: • School counselling and other school interventions • Past referrals • Effectiveness of previous treatments • Side-effects and complications associated with previous treatments • Patient's preference for medications	
Allergies	
Relevant physical examination and other investigations	
Results of relevant previous psychological and developmental testing	
Other care plan e.g. GP Management Plans and Team Care Arrangements; Wellness Recovery Action Plan	☐ Yes, Specify: ☐ No

Comments on Current <u>Mental State Examination</u>

Consider: • Appearance, cognition, thought process, thought content, attention, memory, insight, behaviour, speech, mood and affect, perception, judgement, orientation.	

<u>Risk assessment</u> **If high level of risk indicated, document actions taken in Treatment Plan below** Consider: • Does the patient have a timeline for acting on a plan? • How bad is the pain/distress experienced? • Is it interminable, inescapable, intolerable?		**Ideation/ thoughts**	**Intent**	**Plan**
	Suicide			
	Self harm			
	Harm to others			
	Comments or details of any identified risks			

<u>Assessment/outcome tool used,</u> except where clinically inappropriate. • e.g., Strengths and Difficulties Questionnaire • Note: K-10 is not validated for minors	
<u>Date of assessment</u>	

Results	☐ Copy of completed tool provided to referred practitioner
Provisional diagnosis of mental health disorder Consider conditions specified in the ICPC, including: • Anxiety co-morbid with Autism • ADD/ADHD • Conduct disorder • Oppositional defiant disorder • Mood disorder • Separation anxiety • Phobias • Elective mutism • Reactive attachment disorder • Nonorganic enuresis and encopresis • Eating disorder • Adjustment disorder (e.g. grief/loss/ parental separation/trauma/medical condition) • Depression • Anxiety • Unexplained somatic disorder • Mental disorder not otherwise specified	
Case formulation Consider: • Predisposing factors • Precipitating factors • Perpetuating factors • Protective factors	
Other relevant information from carer/informants Consider: • Specific concerns of carer/family • Impact on carer/family • Contextual information from members of patient's community • Other content from individuals other than the patient	
Any other comments	

PLAN				
		Actions		
Identified issues/problems Consider: • As presented by patient • Developed during consultation • Formulated by GP	**Goals** Consider: • Goals made in collaboration with patient • What does the patient want to see as an outcome from this plan? • Behavioural or symptomatic goals • Wellbeing, function, occupation, relationships • Any reference to special outcome measures • Time frame	**Treatments & interventions** Consider: • Suggested psychological interventions • Medications • Key actions to be taken by patient and by guardians • Support services to achieve patient goals • Parent Management Training • Role of GP • Psycho-education • Time frame	**Referrals** Consider: • Practitioner, service or agency—referred to whom and what for • Specific referral request • Opinion, planning, treatment • Case conferences • Time frame	**Any role of carer/support person(s)** Consider: • Identified role or task(s), e.g. monitoring, intervention, support • Discussed, agreed, negotiated with carer? • Any necessary supports for carer • Time frame
Issue 1:				
Issue 2:				
Issue 3:				
Intervention/relapse prevention plan (if appropriate at this stage) Consider: • Identify warning signs from past experiences • Note arrangements to intervene in case of relapse or crisis • Other support services currently in place • Note any past effective strategies				
Psycho-education provided if not already addressed in "treatments and interventions" above?			☐ Yes ☐ No	
Plan added to the patient's records?			☐ Yes ☐ No	

Other healthcare providers and service providers involved in patient's care
(e.g. psychologist, psychiatrist, social worker, occupational therapist, other GPs, other medical specialists, case worker, community mental health services)

Role	Name	Address	Phone

COMPLETING THE PLAN

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

RECORD OF PATIENT CONSENT

I, _____*(name of patient or guardian)*, agree to information about my/my charge's health being recorded in my medical file and being shared between the General Practitioner and other health care providers involved in my/his/her care, as nominated above, to assist in the management of my/my charge's health care. I understand that I must inform my GP if I wish to change the nominated people involved in my/my charge's care.

I understand that as part of my/my charge's care under this Mental Health Treatment plan, I/he/she should attend the General Practitioner 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.

(Full name of GP)

_____ _____/_____/_____

(Signature of GP) *(Date)*

REVIEW	
MBS ITEM NUMBER: ☐ 2712 ☐ 2719	
Planned date for review with GP (initial review 4 weeks to 6 months after completion of plan)	
Actual date of review with GP	
Assessment/outcome tool results on review. except where clinically inappropriate	
Comments Consider: • Progress on goals and actions • Have identified actions been initiated and followed through? e.g. referrals, appointments, attendance • Checking, reinforcing and expanding education • Communication • Where appropriate, communication received from referred practitioners • Modification of treatment plan if required	
Intervention/relapse prevention plan (if appropriate) Consider: • Identify warning signs from past experiences • Note arrangements to intervene in case of relapse or crisis • Other support services currently in place • Note any past effective strategies	