

**GP MENTAL HEALTH TREATMENT PLAN
PATIENT ASSESSMENT**

Patient's Name		Date of Birth	
Address		Phone	
Carer details and/or emergency contact(s)		Other care plan Eg GPMP / TCA	YES ☐ NO ☐
GP Name / Practice			
AHP or nurse currently involved in patient care		Medical Records No.	
PRESENTING ISSUE(S) What are the patient's current mental health issues			
PATIENT HISTORY Record relevant biological psychological and social history including any family history of mental disorders and any relevant substance abuse or physical health problems			
MEDICATIONS (attach information if required)			
ALLERGIES			
ANY OTHER RELEVANT INFORMATION			
RESULTS OF MENTAL STATE EXAMINATION Record after patient has been examined			
RISKS AND CO-MORBIDITIES Note any associated risks and co-morbidities including risks of self harm &/or harm to others			
OUTCOME TOOL USED	RESULTS		
DIAGNOSIS			

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PATIENT PLAN**

PATIENT NEEDS / MAIN ISSUES	GOALS Record the mental health goals agreed to by the patient and GP and any actions the patient will need to take	TREATMENTS Treatments, actions and support services to achieve patient goals	REFERRALS Note: Referrals to be provided by GP, as required, in up to two groups of six sessions. The need for the second group of sessions to be reviewed after the initial six sessions.
Fatigue Cognitive difficulties Sleep-wake cycle disturbance Mood disturbance Poor coping	Improve physical functional capacity Improve cognitive functional capacity Restore sleep-wake cycle patterns Improve mood Develop coping strategies	Activity pacing & graded exercise therapy Cognitive remediation sleep-wake cycle management Cognitive behavioural therapy for mood disturbance Resilience and coping strategies	UNSW Fatigue Clinic – Clinical Psychologist (6 sessions)
CRISIS / RELAPSE If required, note the arrangements for crisis intervention and/or relapse prevention			
APPROPRIATE PSYCHO-EDUCATION PROVIDED YES ☐ NO ☐		PLAN ADDED TO THE PATIENT'S RECORDS YES ☐ NO ☐	COPY (OR PARTS) OF THE PLAN OFFERED TO OTHER PROVIDERS YES ☐ NO ☐ NOT REQ'D ☐
COMPLETING THE PLAN On completion of the plan, the GP is to record that s/he has discussed with the patient: - the assessment; - all aspects of the plan and the agreed date for review; and - offered a copy of the plan to the patient and/or their carer (if agreed by patient)			
DATE PLAN COMPLETED		REVIEW DATE (initial review 4 weeks to 6 months after completion of plan)	
REVIEW COMMENTS (Progress on actions and tasks) Note: If required, a separate form may be used for the Review.			OUTCOME TOOL RESULTS ON REVIEW