



GP MENTAL HEALTH CARE PLAN (2710)

Date of Assessment	
Patients Name	DOB
Address	Phone
Carer's Details	
GP Name	Address
Phone	Medicare Provider #

PRESENTING COMPLAINTS

PATIENT HISTORY

Relevant biological,
psychological and social history

CURRENT
MEDICATIONS

ANY OTHER
RELEVANT INFORMATION

RISKS AND/OR
COMORBIDITIES

DIAGNOSTIC TOOL
USED UPON ASSESSMENT

OUTCOME

TREATMENT
REQUIREMENTS

GP MENTAL HEALTH CARE PLAN (2710) cont ...

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.

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 required

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)

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

(Adapted from the black dog Inst 2010)