260 Loganlea Road, Meadowbrook OLD 4131

phone: 07 3804 4200 *II* fax : 07 3804 4299 *II* email: headspace.meadowbrook@aftercare .com.au

Mental Health Care Plan and Referral (2715,2717)

|  |  |
| --- | --- |
| Patient Name: | Date of Birth: |
| Address: | Phone: |
| Referring GP Name:**Dr Nicolas Lenskyj****Provider No #5160383X** | Practice Address :**260 Loganlea Road,****Meadowbrook QLD 4131** |

|  |
| --- |
| Description of Presenting Problem/Complaint: |
| Relevant Medication: |
| Mental Health History/Previous Treatment: |
| Family History of Mental Illness: |
| Social History (Substance Use, Current Relationships, Current Employment Status): |
| Relevant Medical Conditions: |

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# Mental Status Examination

|  |  |
| --- | --- |
| Appearance: | Mood: |
| Thinking : | Affect: |
| Attention/Concentration: | Sleep: |
| Appetite: | Motivation/ Energy: |
| Memory: | Judgement/Insight: |
| Orientation: | Speech: |

**Risk Assessment** (tick the relevant answers)

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Suicidal Thoughts : | **🞏** | Yes | 🞏 | No | Suicidal Intent: | **🞏** | Yes | 🞏 | No |
| Current | Plan: | 🞏 | Yes | **🞏** | No | Risk to | Others : | **🞏** | Yes | 🞏 | No |

## **Crisis Management Plan** (tick each box once you have discussed the option with the patient) In case of a crisis, the patient will contact:

|  |  |
| --- | --- |
| **🞏** | Metro South Mental Health Service : 1300 642 255 |
| 🞏 | Lifeline: 13 11 14 |
| **🞏** | Family Contact *I* Other : |

**Provisional Diagnosis** (mark the relevant boxes and provide any additional relevant information)

|  |  |
| --- | --- |
| 🞏 | Alcohol and Drug Use: |
| **🞏** | Anxiety Disorders: |
| **🞏** | Mood Disorders/ Depression: |
|  **🞏** | Behavioral Problems : |
| 🞏 | Adjustment Disorders: |
| 🞏 | Psychotic Disorders : |
| 🞏 | Unknown/Other : |

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**Assessments - Patient to Complete**

K10 - for all questions, please mark the appropriate response box. In the past 4 weeks:

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| In the past 4 weeks , about how often did you fee l: | 1None of the time | 2A little of the time | 3Some of the time | 4Most of the time | 5All the time |
| 1. Tired? |  |  |  |  |  |
| 2. Nervous? |  |  |  |  |  |
| 3. So nervous that nothing could calm you down? |  |  |  |  |  |
| 4. Hopeless? |  |  |  |  |  |
| 5. Restless or fidgety? |  |  |  |  |  |
| 6. So restless that you could not sit still? |  |  |  |  |  |
| 7. Depressed? |  |  |  |  |  |
| 8. That everything is an effort? |  |  |  |  |  |
| 9. So sad that nothing could cheer you up? |  |  |  |  |  |
| 10. Worthless? |  |  |  |  |  |
| **Total =** |  |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| In the past 2 weeks, about how often did you feel : | 1None of the time | 2A little of the time | 3Some of the time | 4Most of the time | 5All the time |
| 1. Good about yourself? |  |  |  |  |  |
| 2. Interested in new things? |  |  |  |  |  |

|  |  |
| --- | --- |
| On a scale of 1 to 10, with 1 = not at all satisfied and 10 = totally satisfied: | Score |
| 1. How satisfied are you with your family life? |  |
| 2. How satisfied are you with your friendships? |  |
| 3. How satisfied are you with your romantic relationships? |  |
| 4. How satisfied are you with your school *I* work experience? |  |
| 5. How satisfied are you with yourself? |  |
| 6. How satisfied are you with where you live? |  |
| 7. How satisfied are you with your life overall? |  |

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**Plan and Referral** (this referral is for an initial series of six sessions unless otherwise stated)

|  |  |  |
| --- | --- | --- |
| **Patient Areas of Concern** | **Patient and GP Goals** | **Referral to Relevant Service Provider** |
|  |  | **🞏 headspace****🞏** Other : |
|  |  | **🞏 headspace**🞏 Other: |
|  |  | **🞏 headspace**🞏 Other: |

**Actions** (mark once complete)

|  |  |
| --- | --- |
| **🞏** | Discussed assessment and diagnosis with the patient |
| **🞏** | Provided psycho-education to the patient |
| **🞏** | Discussed MHCP and Review process with the patient |
| **🞏** | Offered a copy of the Mental Health Care Plan to the patient |

# Patient Consent

## I agree to the completion of this mental health care plan, and understand the recommendations. Patient Signature:

**General Practitioner Details**

Please accept the referral of this patient.

Date of Completion of Plan: Date of Review:

GP Signature:

GP Provider Number: 5160383X