

**ISML Mental Health Assessment,
Treatment Plan and Referral Form
STEP 1: PATIENT ASSESSMENT**

Patient's Name:	Date of Birth:	Age: <input type="checkbox"/> 12-25 <input type="checkbox"/> 26+
Address:	Phone (Home): Mobile: Phone (Work): Medicare Number:	
Carer/Emergency contact(s):	Aboriginal / Torres Straight Islander <input type="checkbox"/> Yes <input type="checkbox"/> No	
GP Name:	Date of Assessment, Plan & Referral:	
Practice:	Other Care Plan e.g. GPMP / TCA <input type="checkbox"/> Yes <input type="checkbox"/> No	
Phone Number:	Level of Priority for consultation:	
Medicare Provider Number:	<input type="checkbox"/> Low <input type="checkbox"/> Moderate <input type="checkbox"/> High	

Result of Risk Assessment	<input type="checkbox"/> Suicidal <input type="checkbox"/> Homicidal <input type="checkbox"/> Impulsivity <input type="checkbox"/> Self-Harm <input type="checkbox"/> Domestic violence <input type="checkbox"/> Nil Risk <input type="checkbox"/> Unknown <input type="checkbox"/> Highly Changeable <input type="checkbox"/> Other:
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Medications/Allergies	
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Presenting Issues What are the patient's current mental health issues? <i>(Tick appropriate boxes, and provide any further appropriate information)</i>	<input type="checkbox"/> Anxiety <input type="checkbox"/> GAD <input type="checkbox"/> OCD <input type="checkbox"/> Social Phobia <input type="checkbox"/> PTSD <input type="checkbox"/> Panic Disorder <input type="checkbox"/> Agoraphobia <input type="checkbox"/> Mood Disorder <input type="checkbox"/> Depression <input type="checkbox"/> Dysthymia <input type="checkbox"/> Perinatal (Ante/Post Natal) <input type="checkbox"/> Depression <input type="checkbox"/> Anxiety (including PTSD) <input type="checkbox"/> Psychosis <input type="checkbox"/> Serious Mental Illness <input type="checkbox"/> Schizophrenia <input type="checkbox"/> Schizoaffective <input type="checkbox"/> Other: <input type="checkbox"/> Personality Disorder <input type="checkbox"/> Borderline <input type="checkbox"/> Anti Social <input type="checkbox"/> Avoidant <input type="checkbox"/> Dependent <input type="checkbox"/> Other Issues (specify) : <input type="checkbox"/> Substance Use / Misuse (specify) : History of Presenting Problem: <i>(eg. when the problem first started, triggers, course of problem)</i> Current Mental State (specify) : Relevant Physical Health Problems (specify) :
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Outcome Tool: <i>(Please fax)</i>	<input type="checkbox"/> DASS 21 <input type="checkbox"/> Edinburgh PND Scale <input type="checkbox"/> Other - Please identify:
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Relevant Background Issues/Other Relevant Information <i>(Tick appropriate boxes and provide any further appropriate information):</i>	<input type="checkbox"/> Previous trauma/abuse/sexual assault (details): <input type="checkbox"/> Family History of Mental Illness (details):	<input type="checkbox"/> Autism Spectrum (specify): <input type="checkbox"/> Behavioral problems <input type="checkbox"/> ADHD/ADD <input type="checkbox"/> Conduct Disorder <input type="checkbox"/> Intellectual disability <input type="checkbox"/> Learning difficulty <input type="checkbox"/> Language difficulty <input type="checkbox"/> Other (specify):
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Social History <i>(Tick appropriate boxes and provide any further appropriate information):</i>	Income Status: <input type="checkbox"/> Full Time Employment <input type="checkbox"/> Part-Time/Casual Employment <input type="checkbox"/> Unemployed/New Start <input type="checkbox"/> Disability Support Pension/Aged Pension Highest education level achieved: <input type="checkbox"/> Year 10 <input type="checkbox"/> Year 12 <input type="checkbox"/> University	Relationship Status : <input type="checkbox"/> Married / De Facto <input type="checkbox"/> Separated / Divorced <input type="checkbox"/> In a relationship <input type="checkbox"/> Single Living Situation: <input type="checkbox"/> Lives with Family/Friends <input type="checkbox"/> Lives Alone <input type="checkbox"/> Other (specify):
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**ISML Mental Health Assessment,
Treatment Plan and Referral Form
STEP 2: PATIENT CARE PLAN**

Patient Name:				
PATIENT NEEDS/MAIN ISSUES	GOALS	TREATMENTS	REFERRALS	REVIEW

CRISIS/RELAPSE PLAN (specify):				
APPROPRIATE PSYCHO-EDUCATION PROVIDED <input type="checkbox"/> Yes <input type="checkbox"/> No	PLAN ADDED TO THE PATIENT'S RECORDS <input type="checkbox"/> Yes <input type="checkbox"/> No	COPY (OR PARTS) OF THE PLAN OFFERED TO OTHER PROVIDERS <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Required		

COMPLETING THE PLAN
In completing this Mental Health Treatment Plan I have discussed with the patient:

the assessment all aspects of the plan, including referrals to other providers

the possibility of a case conference occurring with other care providers

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: <i>(initial review 4 weeks to 6 months after completion of plan)</i>
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REFERRAL AND PATIENT CONSENT

I _____ (GP name) am referring this patient for treatment with (please tick)

Mental Health Nurse - up to 2 years support (patients with severe mental illness and complex needs under Medicare)

Perinatal Mental Health Service - 6 individual sessions (ATAPS)

Perinatal Mental Health Service - 12 group sessions (ATAPS)

Clinical Psychology Service - indicate no. of individual sessions ie. 6 (Medicare)

Sleep Group - 2 group sessions (ATAPS) **headspace (12-25 years) Fax to 4225 0057**

I have discussed the proposed referral with the patient and am satisfied that the patient understands the reason for the referral.

GP Signature: _____ **Date:** _____

I _____ (patient name) declare that my GP has explained why I have been referred to the above service. I agree to information about my mental health and wellbeing, medical and social history being shared between my GP and the appropriate staff involved in the management of my health care. I understand that this may occur during a case conference.

Patient Signature: _____ **Date:** _____

FAX THIS ASSESSMENT, PLAN AND REFERRAL TO THE ISML SECURE FAX NUMBER: 4226 6489

**Please Note: the ISML does not provide a crisis service. Patients with acute mental illness are not appropriate for referral to the ISML and must be referred to the mental health intake service
ph: 1300 552 289 (24 hrs)**