



GP Mental Health Care Plan (MBS Item 2710)

Patient Assessment

Patient's Name:		Assessment Date:	
Address:		Date of Birth	
GP Name:		Phone Home:	
Practice Name:		Phone Mobile:	

Presenting Issue(s) What are the patient's current mental health issues	
Current Medications	
Mental Health History / Treatment	
Family History of Mental Illness	
Medical Conditions	
Social History	
Substance Use / Lifestyle Factors (eg Alcohol, Smoking)	
Allergies	
Personal History (eg childhood, education relationship history, coping with previous stressors)	
Any Other Relevant Information	

Mental State Examination	
Appearance and General Behaviour	
Mood / Affect (Depressed / Labile)	
Thinking (Content / Rate / Disturbances)	
Perception (Hallucinations etc)	
Cognition (Level of Consciousness / Delirium / Intelligence)	
Attention / Concentration	
Memory (Short & Long Term)	
Insight	



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Patient Assessment

Orientation (Time / Place / Person)	
Sleep (Initial Insomnia / Early Morning Wakening)	
Appetite (Disturbed Eating Patterns)	
Motivation / Energy	
Judgement (Ability to make rational decisions)	
Anxiety Symptoms (Physical and Emotional)	
Speech (Volume / Rate / Content)	
Outcome Tool Used e.g. K10	Results
Relevant Physical Examination	
Relevant Investigations	

Risk Assessment

Risk of Self Harm	
Risk to Others	
Key Family Contact / Support	

Formulation

Main Problems / Diagnosis	
Cultural Factors	
Predisposing Factors	
Precipitating Factors	
Perpetuating Factors	
Protective Factors	
Management	