MENTAL HEALTH ASSESSMENT & PLAN

Patient name		Date of Birth	
Address			

Post Code		Phone		Gender	
GP				Practice postcode	
Date of Assessment		Outcome Tool		Result	

Aboriginal or Torres Strait Islander origin	No ☐ Aboriginal ☐ Torres Strait Islander ☐ Both ☐ Unknown ☐
Allied Health Referral Data	Has the person ever received specialist mental health care: Yes ☐ No ☐ Unknown ☐ Does the person speak a language other than English at home: No ☐ Yes ☐ If yes, please specify:……………………………………………
	Does the person live alone: Yes ☐ No ☐ Unknown ☐ Is the person a low income earner (A judgement by GP): Yes ☐ No ☐
	Highest education level completed: Primary or below ☐ Secondary: Year 10 or equivalent ☐ Secondary: Year 11 or equivalent ☐ Secondary: Year 12 or equivalent ☐ Tertiary ☐

Problem/Issue	Goal	Action/Task
	(e.g. Reduce symptoms, improve functioning)	(e.g. Referral for Allied Health, or pharmacological treatment, or engagement of family/other supports)
1.		
2.		

Medical Conditions

Relevant Medications	Allergies
Please list: ☐ Antidepressants ________________ ☐ Benzodiazepines & Anxiolytics ________________ ☐ Phenothiazines & Tranquillisers ________________ ☐ Mood stabilisers ________________ Other: ________________	

Relevant Physical and Mental Examination	Previous Investigations

Medical Health History / Treatment / Family History of Mental Illness

Personal History / Social History (e.g. childhood, education, relationship history, coping with previous stressors)

Abuse history – substance / sexual / physical

Alcohol use: Tobacco use:

Past Sexual Abuse ☐ Past Physical Abuse ☐ Drug Abuse ☐

Mental Status Examination

Appearance and General Behaviour	Mood (Depressed / Labile)
Thinking (Content / Rate / Disturbances)	Affect (Flat / Blunted)
Perception (Hallucinations etc)	Sleep (Initial Insomnia / Early Morning Wakening)
Cognition (Level of Consciousness / Delirium / Intelligence)	Appetite (Disturbed Eating Patterns)
Attention / Concentration	Motivation / Energy
Memory (Short & Long term)	Judgement (Ability to make rational decisions)
Insight	Anxiety Symptoms (Physical & Emotional)
Orientation (Time / Place / Person)	Speech (Volume / Rate / Content)

Risk Assessment

Suicidal ideation		Suicidal intent	
Current plan		Risk to Others	
Key Family/ Support Contact			

FORMULATION – Main problem / diagnosis	ICD – 10 Provisional Diagnosis
(risk / protective factors)	F1 Alcohol & Drug Use disorder ☐
	F2 Psychotic Disorder ☐
	F3 Depression ☐
	F4 Anxiety Disorder ☐
	F5 Unexplained Somatic Disorder ☐
	Other / Unknown:

Allied Health Referral Data

Intervention Requested		Cognitive Behavioural Therapy (CBT):	
Diagnostic assessment	Yes ☐ No ☐	Behavioural interventions	Yes ☐ No ☐
Psycho-education	Yes ☐ No ☐	Cognitive interventions	Yes ☐ No ☐
Interpersonal Therapy	Yes ☐ No ☐	Relaxation strategies	Yes ☐ No ☐
Other (specify)		Skills training	Yes ☐ No ☐
		Other CBT interventions	Yes ☐ No ☐

Patient Education	Yes ☐ No ☐	Copy of MH plan given to patient	Yes ☐ No ☐

I understand the above Mental Health Plan and agree to the outlined goals / actions	
Patient Signature	GP Signature

Proposed date for Mental Health Review (between 4 weeks – 6 months)	

Follow Up / Relapse Prevention Plan (if appropriate)

Emergency Care