

MENTAL HEALTH PLAN & REVIEW

Patient Name (or label)		Date of Birth	
		GP Name	
Date of Mental Health Plan		Proposed Date of Mental Health Review (between 4 weeks – 6 months)	
Problem / Issue	GOAL (eg. Reduce symptoms, improve functioning)	ACTION / TASK (eg. Referral for Allied Health, or pharmacological treatment, or engagement of family/other supports)	PROGRESS (at review)
1.			
2.			

Allied Health Referral Data

Intervention Requested		Cognitive Behavioural Therapy (CBT):	
Diagnostic assessment	Yes <input type="checkbox"/> No <input type="checkbox"/>	Behavioural interventions	Yes <input type="checkbox"/> No <input type="checkbox"/>
Psycho-education	Yes <input type="checkbox"/> No <input type="checkbox"/>	Cognitive interventions	Yes <input type="checkbox"/> No <input type="checkbox"/>
Interpersonal Therapy	Yes <input type="checkbox"/> No <input type="checkbox"/>	Relaxation strategies	Yes <input type="checkbox"/> No <input type="checkbox"/>
Other (specify)		Skills training	Yes <input type="checkbox"/> No <input type="checkbox"/>
		Other CBT interventions	Yes <input type="checkbox"/> No <input type="checkbox"/>
		Consent form signed by patient (to share clinical notes)	Yes <input type="checkbox"/> No <input type="checkbox"/>

Follow Up / Relapse Prevention Plan (if appropriate)

Emergency Care

Notes

Patient Education given 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

X

GP Signature

X

Mental Health Review

Date

Outcome Tool		Result at assessment		Result at review	
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Further Actions/Tasks or Notes

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