

GP MENTAL HEALTH TREATMENT PLAN – SOAP

Notes: This form is designed for use with the following MBS items. Users should be familiar with the most recent item definitions and requirements.

MBS ITEM NUMBER: 2700 2701 2715 2717

Major headings are **bold**; prompts to consider lower case. Response fields can be expanded as required. **Underlined items of either type are mandatory for compliance with Medicare requirements.**

This document is not a referral letter. A referral letter must be sent to any additional providers involved in this mental health treatment plan.

CONTACT AND DEMOGRAPHIC DETAILS

GP name		GP phone	
GP practice name		GP fax	
GP address		Provider number	
Relationship	This person has been my patient since		
	<i>and/or</i>		
	This person has been a patient at this practice since		
Patient surname		Date of birth (dd/mm/yy)	
Patient first name(s)		Preferred name	
Gender	<input type="checkbox"/> Female <input type="checkbox"/> Male <input type="checkbox"/> Self-identified gender:		
Patient address			
Patient phone	Preferred number:	Alternative number:	
	Can leave message? <input type="checkbox"/> Yes <input type="checkbox"/> No	Can leave message? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Medicare No.		Healthcare Card/Pension No.	

Carer/support person contact details			Has patient consented for this healthcare team to contact carer/support persons?	
First contact:	Relationship:	Phone number 1: Phone number 2:	<input type="checkbox"/> Yes With the following restrictions:	<input type="checkbox"/> No
Second contact:	Relationship:	Phone number 1: Phone number 2:	<input type="checkbox"/> Yes With the following restrictions:	<input type="checkbox"/> No
Emergency contact person details			Patient consent for healthcare team to contact emergency contacts?	
First contact:	Relationship:	Phone number 1: Phone number 2:	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Second contact:	Relationship:	Phone number 1: Phone number 2:	<input type="checkbox"/> Yes	<input type="checkbox"/> No
SALIENT COMMUNICATION AND CULTURAL FACTORS				
Language spoken at home	<input type="checkbox"/> English	<input type="checkbox"/> Other:		
Interpreter required	<input type="checkbox"/> No	<input type="checkbox"/> Yes, Comments:		
Country of birth	<input type="checkbox"/> Australia	<input type="checkbox"/> Other:		
Other communication issues				
Other cultural issues				

S – “SUBJECTIVE”

Consider:

- Reasons for presenting
- History of current episode
- Mental health history
- Salient social history
- Salient medical/biological history
- Salient developmental issues
- Family history of mental illness/suicidal behaviour
- Current domestic and social circumstances, including relationships and occupation
- Salient substance use issues
- Medications: current and previous, including effectiveness and side effects for mental disorders

O – “OBJECTIVE”

Comments on current mental state examination

Consider:

- Appearance, cognition, thought process, thought content, attention, memory, insight, behaviour, speech, mood and affect, perception, judgement, orientation.
- Appropriateness of Mini Mental State Examination for patients over 75 years or if otherwise indicated

Allergies

Relevant physical examination and other investigations

Results of relevant previous psychological and developmental testing

A – “ASSESSMENT”

<p><u>Risk assessment</u> If high level of risk indicated, document actions taken in Treatment Plan below Consider:</p> <ul style="list-style-type: none"> • Does the patient have a timeline for acting on a plan? • How bad is the pain/distress experienced? • Is it interminable, inescapable, intolerable 		Ideation/ thoughts	Intent	Plan
<p><u>Assessment/outcome tool used,</u> except where clinically inappropriate. Include:</p> <ul style="list-style-type: none"> • Date of assessment • Results 				
<p><u>Case formulation and provisional diagnosis of mental health disorder</u> Consider:</p> <ul style="list-style-type: none"> • Predisposing factors • Precipitating factors • Perpetuating factors • Protective factors <p>Possible diagnoses:</p> <ul style="list-style-type: none"> • Depression • Bipolar disorder • Other mood disorders • Anxiety disorders • Panic disorder • Phobic disorders • Post-traumatic stress disorder • Schizophrenia • Other psychotic disorders • Adjustment disorder • Dissociative disorders • Eating disorders • Impulse-control disorders • Sexual disorders • Sleep disorders • Somatoform disorders • Substance-related disorders • Personality disorders • Unknown 				
	Suicide			
	Self harm			
	Harm to others			
	Comments or details of any identified risks			

P – “PLAN”

Patient goals

Treatments & interventions

Consider:

- Psychological interventions
- Face to face
- internet-based
 - [myCompass](#)
 - [THIS WAY UP](#)
 - [MindSpot](#)
 - [e-couch](#)
 - [MoodGYM](#)
 - [Mental Health Online](#)
 - [OnTrack](#)
- Pharmacological interventions
- Support services
- Psycho-education
- Key actions to be taken by patient

Referrals

Consider:

- referral to internet mental health programs for education and/or specific psychotherapy
 - [myCompass](#)
 - [THIS WAY UP](#)
 - [MindSpot](#)
 - [e-couch](#)
 - [MoodGYM](#)
 - [Mental Health Online](#)
 - [OnTrack](#)

Role of carer/support person

Intervention/relapse prevention plan

(if appropriate at this stage)

Consider:

- Identify warning signs from past experiences
- Note arrangements to intervene in case of relapse or crisis
- Other support services currently in place
- Note any past effective strategies

Other healthcare providers and service providers involved in patient’s care

(e.g. psychologist, psychiatrist, social worker, occupational therapist, other GPs, other medical specialists, accommodation, case manager).

Role	Name	Address	Phone

COMPLETING THE PLAN

On completion of the plan, the GP may record (tick boxes below) that s/he has:

Date plan completed

<input type="checkbox"/> discussed the assessment with the patient <input type="checkbox"/> discussed all aspects of the plan and the agreed date for review <input type="checkbox"/> offered a copy of the plan to the patient and/or their carer (if agreed by patient)	
Plan added to the patient's records?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Copy of the plan offered to other providers?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not required

RECORD OF PATIENT CONSENT

I, _____ (*name of patient*), agree to information about my health being recorded in my medical file and being shared between the General Practitioner and other health care providers involved in my care, as nominated above, to assist in the management of my health care. I understand that I must inform my GP if I wish to change the nominated people involved in my care.

I understand that as part of my care under this Mental Health Treatment plan, I should attend the General Practitioner for a review appointment at least 4 weeks after but within 6 months after the plan has been developed.

I consent to the release of the following information to the following carer/support and emergency contact persons:

Name	Assessment		Treatment Plan	
	Yes	No	Yes	No
	<input type="checkbox"/> with the following limitations:	<input type="checkbox"/>	<input type="checkbox"/> with the following limitations:	<input type="checkbox"/>
	<input type="checkbox"/> with the following limitations:	<input type="checkbox"/>	<input type="checkbox"/> with the following limitations:	<input type="checkbox"/>

_____ / ____ / ____
(Signature of patient) *(Date)*

I, _____, have discussed the plan and referral(s) with the patient.
(Full name of GP)

_____ / ____ / ____
(Signature of GP) *(Date)*

REVIEW

MBS ITEM NUMBER: 2712 2719

Planned date for review with GP
(initial review 4 weeks to 6 months after completion of plan)

Actual date of review with GP

Assessment/outcome tool results on review,
except where clinically inappropriate

Comments

Consider:

- Progress on goals and actions
- Have identified actions been initiated and followed through? e.g. referrals, appointments, attendance
- Checking, reinforcing and expanding education
- Communication
- Where appropriate, communication received from referred practitioners
- Modification of treatment plan if required

Intervention/relapse prevention plan
(if appropriate)

Consider:

- Identify warning signs from past experiences
- Note arrangements to intervene in case of relapse or crisis
- Other support services currently in place
- Note any past effective strategies