

Appendix 3

<p>Mental Health Act 1986</p> <p>Section 19A</p> <p>Mental Health Statewide Patient Number <input style="width: 100px; height: 20px;" type="text"/></p>	<p>Local Hospital Patient Number: _____</p> <p>Family Name: _____</p> <p>Given Names: _____</p> <p>Date of Birth: _____ Sex: _____</p> <p>Alias: _____</p>
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APPENDIX 3

ASSESSMENT & TREATMENT PLAN

<p>Notes to completing this form</p> <p>This plan may be used by CAMHS services for young people who are receiving services.</p> <p>The purpose of this plan is to give the young person and their responsible parent/guardian a plain statement of the services they will receive from the CAMHS service.</p> <p>It must identify the young person's immediate needs/presenting problems and the actions that will be taken to meet those needs.</p> <p>The expected outcomes must be realistic, focused on recovery and achievable within the expected life of the plan.</p> <p>Preparation of the plan provides a basis for discussion with the young person and their parent/guardian. In developing this plan, you must take into account the wishes of:</p> <ul style="list-style-type: none"> • the young person, as far as they can be ascertained. • the responsible parent/guardian. <p>The young person and the parent/guardian should be given a copy of this <i>Assessment & Treatment Plan</i> and the information explained.</p> <p>Authorisation</p> <p>Where a psychiatrist is not immediately available to sign the form, a designated senior clinician within the service may authorise the plan until such time as a psychiatrist is available.</p>	<p>.....</p> <p style="text-align: center;">GIVEN NAME/S FAMILY NAME (BLOCK LETTERS) of consumer</p> <p>.....</p> <p style="text-align: center;">address of consumer</p> <hr/> <p>TREATING TEAM</p> <p>(1) Psychiatrist:</p> <p>(2) Treating doctor:</p> <p>(3) Case manager / clinician:</p> <p>(4) Clinic / service where you will receive services / treatment from:</p> <p style="text-align: right;">..... telephone:</p> <hr/> <p>OTHER PARTIES TO THE PLAN</p> <p>(5) General practitioner/paediatrician: telephone:</p> <p>(6) Private practitioner: telephone:</p> <p>(7) Parent/guardian: telephone:</p> <p>(8) Other: telephone:</p> <hr/> <p>REVIEW DATE</p> <p>(9) This plan is due for review on: / /</p> <hr/> <p>Prepared by:</p> <p>.....</p> <p style="text-align: center;">GIVEN NAME/S FAMILY NAME (BLOCK LETTERS) of clinician completing form</p> <p>Signed: Designation: Date: / /</p> <hr/> <p>Authorised by:</p> <p>.....</p> <p style="text-align: center;">GIVEN NAME/S FAMILY NAME (BLOCK LETTERS) of * delegated/ authorised psychiatrist / senior clinician</p> <p>Signed: Designation: Date: / /</p> <p>* delete as necessary</p>
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