MHA4

Mental Health Act 1986

Section 19A

Local Hospital Patient Number:

Family Name:

Given Names:

Date of Birth: **Sex:**

Alias:

Mental Health Statewide Patient Number

Mental Health Act 1986

Section 19A

Local Hospital Patient Number:

Family Name:

Given Names:

Date of Birth: **Sex:**

Mental Health Statewide Patient Number

Alias:

TREATMENT PLAN

Notes to completing this form

The purpose of this plan is to give the patient a plain statement of the treatment they will receive from the mental health service.

It must identify the patient's immediate needs and the actions that will be taken to meet those needs.

The expected outcomes must be realistic, focused on recovery and achievable within the expected life of the plan.

Preparation of the plan provides a basis for discussion with the patient and their nominated carer/s. In developing this plan, you must take into account the wishes of:

- the patient, as far as they can be ascertained.
- nominated carer/s who are involved in providing ongoing care or support to the patient, unless the patient objects.

The patient must be given a copy of this *Treatment Plan* and the information explained.

Review
A treatment plan will be reviewed by the treating team as often as clinically necessary.

Further Information
The Chief Psychiatrist's guideline *Treatment Plan* is available at: www.health.vic.gov.au/mentalhealth/cpg

GIVEN NAME/S FAMILY NAME (BLOCK LETTERS) of patient

- ☐ an involuntary patient in an approved mental health service.
- ☐ an involuntary patient subject to a community treatment order.
- ☐ an involuntary patient subject to a restricted community treatment order.
- ☐ a security patient.
- ☐ a forensic patient.
- ☐ a person receiving treatment from a mental health service on a voluntary basis.

(please cross ☒ one option)

of: _____
name of approved mental health service/treating mental health service

residing at: _____
address of person if living in the community

TREATING TEAM

(1) Psychiatrist: _____
name of monitoring psychiatrist

(2) Treating doctor: _____
name of supervising medical practitioner

(3) Case manager / primary clinician: _____
name of case manager / primary clinician

(4) Clinic/service where you will receive treatment from: _____

_____ telephone: _____

OTHER PARTIES TO THE PLAN (where applicable)

(5) General practitioner: _____ telephone: _____

(6) Private psychiatrist: _____ telephone: _____

(7) Nominated carer/s: _____ telephone: _____

(8) Other: _____ telephone: _____

REVIEW DATE

(9) This plan is due for review on: ☐☐☐☐☐☐ (see note opposite)

PROGRESS REPORTS (CTO & RCTO patients only)

(10) The *supervising medical practitioner / monitoring psychiatrist must send the *monitoring psychiatrist / chief psychiatrist a progress report every: _____ *month/s.

Prepared by:

GIVEN NAME/S FAMILY NAME (BLOCK LETTERS) of clinician completing form

Signed: _____ Designation: _____ Date: ☐☐☐☐☐☐

Authorised by:

GIVEN NAME/S FAMILY NAME (BLOCK LETTERS) of * delegated/ authorised psychiatrist

Signed: _____ Date: ☐☐☐☐☐☐

* delete as necessary

Writing the plan
- Identify the priority needs and any risk factors to be addressed by this plan.
- Specify what will be done to address each need.
- Specify the expected outcome for each identified need.

Discharge planning
- Where appropriate, the plan will specify discharge planning and follow-up.

Nominated Carer/s
- If nominated carer/s have an agreed role, it should be specified in the plan. They should be given a copy of the plan.

Other Clinicians
- Specify the role of any general practitioner, private psychiatrist and other clinicians, who are partners in the plan. They should be given a copy of the plan.

Crisis response
- Specify the actions the patient and/or their nominated carer/s (including children) should take in the event of a relapse or crisis, including a 24-hour contact number.

Failure to Comply (CTO & RCTO patients only)
- Explain to the patient those parts of the plan that are compulsory, for which failure to comply may result in the CTO / RCTO being revoked.

Signatures
- The patient and/or a nominated carer may choose to sign the plan to indicate an understanding of the plan.
- The clinician who prepares this plan must sign and date this page.

TREATMENT PLAN (Please print)

TO THE PATIENT
Members of the treating team will regularly discuss with you your diagnosis, medication and other methods of treatment, alternative treatments and available services. They will review and update your treatment plan on a regular basis.

Diagnosis: _____

Current psychiatric medication: _____

Treatment plan: _____

Patient's signature: _____ Date: ☐☐☐☐☐☐

Nominated carer's signature: _____ Date: ☐☐☐☐☐☐

Clinician's signature & designation: _____ Date: ☐☐☐☐☐☐

MHA 4 TREATMENT PLAN

ROLLS FILING SYSTEMS (03) 8770 1111

DEC 2004

White - PATIENT Yellow - PATIENT FILE White - ADMIN