MHA4

Mental Health Act 1986

Section 19A

Mental Health Statewide Patient Number | | | | | | | | |

Local Hospital Patient Number: | | | | | | | | | | |

Family Name: ______________________

Given Names: ______________________

Date of Birth: ______________ **Sex:** ________

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

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Family Name: ____________________

Given Names: ____________________

Date of Birth: ____________________ **Sex:** __________

Alias: ____________________

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