

MENTAL HEALTH ASSESSMENT

Patient Name		OUTCOME TOOL	RESULT
DOB			
Date of Assessment			
GP			

Problem/Diagnosis

Number 1

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Number 2

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Number 3

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Mental Health History / Treatment

Medications

Family History of Mental Illness

Medical Conditions

Social History

Substance Use/Lifestyle Factors

Allergies

Personal History (eg childhood, education, relationship history, coping with previous stressors)

Mental Status Examination	Relevant Physical Examination
Appearance and General Behaviour	
Mood/Affect	
Thinking	
Perception	
Cognition	
Attention	Relevant Investigations
Memory	
Insight	

Risk Assessment	Key family contact/support
Risk of Self Harm	
Risk to Others	

FORMULATION		
Main Problems/Diagnosis	Cultural Factors	
Predisposing Factors	Precipitating Factors	Perpetuating Factors
Protective Factors	Management	

Patient Education (please tick)		Date for Mental Health Plan
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MENTAL HEALTH PLAN

Patient Name		OUTCOME TOOL	RESULT
DOB			
Date of Mental Health Plan			
GP			

Problem/Diagnosis	Goal <small>(eg reduce symptoms, improve functioning)</small>	Action/ Task <small>(eg psychological or pharmacological treatment, referral, engagement of family and other supports)</small>
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Number 1		

Number 2		

Number 3		

Emergency Care / Relapse Prevention		

Patient Education (please tick)		Key family contact/support
Copy of MH plan given to patient		

I understand the above Mental Health Plan and agree to the outlined goals/actions		
Patient Signature		Date:
GP Signature		Date:
Date for Mental Health Review (between 1 – 6 months):		
Notes		

MENTAL HEALTH REVIEW

Patient Name		OUTCOME TOOL	RESULT
DOB			
Date of Mental Health Review			
GP			

Problem/Diagnosis	Goal	Progress on Actions & Tasks
Number 1		
Number 2		
Number 3		

Follow-up / Relapse Prevention Plan

Consumer Comments