

RELEVANT HISTORY OF AGRESSION	
MENTAL STATUS EXAMINATION	
Appearance and General Behaviour	Mood (depressed, labile)
Orientation (time, place, person)	Affect (flat, blunted)
Thinking (content, rate, disturbances)	Sleep (initial insomnia, early morning wakening)
Perception (hallucinations)	Appetite (disturbed eating patterns)
Cognition (level of consciousness, delirium, intelligence)	Motivation & Energy
Attention / concentration	Judgment (ability to make rational decisions)
Memory (short term, long term)	Anxiety Symptoms (physical, emotional)
Insight	Speech (speed, rate, content)

FORMULATION Main Problems / Diagnosis	ICD-10 Provisional Diagnosis
	F1 Alcohol & Drug Use Disorder <input type="checkbox"/>
	F2 Psychotic Disorder <input type="checkbox"/>
	F3 Depression <input type="checkbox"/>
	F4 Anxiety Disorder <input type="checkbox"/>
	F5 Unexplained somatic Disorder <input type="checkbox"/>
	Other/Unknown <input type="checkbox"/>

ALLIED HEALTH REFERRAL DATA	
Intervention Requested <input type="checkbox"/>	Cognitive Behavioural Therapy (CBT) <input type="checkbox"/>
Diagnostic Assessment <input type="checkbox"/>	Behavioural Interventions <input type="checkbox"/>
Psycho-education <input type="checkbox"/>	Cognitive Interventions <input type="checkbox"/>
Interpersonal Therapy <input type="checkbox"/>	Relaxation Strategies <input type="checkbox"/>
Other (specify) <input type="checkbox"/>	Skills Training <input type="checkbox"/>
	Other CBT Interventions <input type="checkbox"/>

FOLLOW UP ARRANGEMENTS	
Client Review Date	
I request a joint session with GP & Psychologists <input type="checkbox"/>	

CARE PLAN			
Problem/Issue	Goal	Action	Outcome at Review
1.			
2.			

Date of plan: _____ Copy of care plan given to patient

Outcome tool score at review: _____

GP's Name: _____

Address: _____

GP's Phone Number: _____ Fax Number: _____

Patient Signature: _____ Date: _____

GP Signature: _____ Date: _____