

CARE PLAN

for patients with multidisciplinary care needs
(to be conducted by patient's usual GP)

Use this page to discuss the benefits of a care plan with your patient and to obtain their consent

	GP prepares	Review	GP contributes
care plan	720 <input type="checkbox"/>	724 <input type="checkbox"/>	726 <input type="checkbox"/>
discharge care plan	722 <input type="checkbox"/>		728 <input type="checkbox"/>
RACF care plan			730 <input type="checkbox"/>

PATIENT NAME

DOB

Male Female

Name & contact details of carer

Interpreter required

Yes

No

Medical Practitioner

Medical record/file No.

30/05/01

CARE PLAN HISTORY

Is there a current care plan in existence

Y
N

If so, by whom
Date

Is the patient eligible under Veterans' Affairs

If yes, please ensure this form is available on request from DVA

problem list (COMPLETE MEDICATION REVIEW SHEET SEPARATELY IF APPROPRIATE)

Principal diagnoses (chronic conditions)

Needs expressed by patient and carer or GP
(medical, social, psychosocial)

HEALTH PROVIDERS / SERVICES

Current

Others likely to assist

AUTHORITY TO PROCEED WITH CARE PLAN

My GP has explained the purpose of the care plan and I give / my carer gives permission to prepare a care plan and discuss my medical history and diagnosis with the providers listed.

Note any medical or personal information patient wants withheld from others

I do / do not have any medical or other information I want withheld from other participants.

All participants to retain confidentiality.

I am aware that there is a fee for the preparation of this care plan and a Medicare rebate will be payable

Has a needs assessment (biopsychosocial) been completed

Y
N

If no, appointment for needs assessment has been set for

Date
Time

/ /

CARE PLAN Summary

Summary of goals to be given to patient and all members of care team

PATIENT NAME _____ DOB _____ Carer _____

OTHER CHECKS

	Completed and attached	Recommended	Provider	Date
Case conference	<input type="checkbox"/>	<input type="checkbox"/>		
Medication review	<input type="checkbox"/>	<input type="checkbox"/>		
Other	<input type="checkbox"/>	<input type="checkbox"/>		

GOALS OF PATIENT AND CARERS

This section is for you to summarise the care plan for distribution to patient/carer and all members of care team

PATIENT'S AGREEMENT

I have agreed / my carer has agreed to this care plan and I understand the recommendations.

Signed by Patient / Carer / or Verbal _____ date _____

Signed by GP _____ date _____
Surgery Address, Phone Number _____

I would / would not like a reminder for my care plan assessment in _____ months time.

A review date has been set

Recommend 3 months after care plan

1 month after a discharge care plan organised by GP

6 months if GP is contributing

review date _____