|  |  |  |
| --- | --- | --- |
|  | **MENTAL HEALTH SHARED CARE PLAN** | [**<<Miscellaneous:Date>>**](7) |

|  |  |  |  |
| --- | --- | --- | --- |
| **Name** | <<Patient Demographics:Full Name>> | **Date of Birth** | <<Patient Demographics:DOB>> |
| **General Practitioner** | <<Doctor:Name>> | **GP Practice** | <<Practice/Location:Name>> |
| **MH1 Care Coordinator** |  | **MH Team** |  |

|  |  |  |  |
| --- | --- | --- | --- |
| **Task** | **Responsible** | **How Often** | **Completed** |
| Physical health check: Pulse, BP, weight, waist circumference (unless provided by MH1 Service) | GP/Practice Nurse | Yearly | **[ ]** |
| Review blood test results for preventable risk and complications | GP | Yearly | **[ ]** |
| Assess and advise on lifestyle behaviours  (smoking, alcohol & other drugs, diet, physical activity) | GP/Practice Nurse | Yearly | **[ ]** |
| Review following ccCHiP2 appointment  (may double as annual physical health check) | GP/Practice Nurse | As required | **[ ]** |
| Order/review other preventive screening as required (e.g., colorectal, breast, cervical, prostate, skin) | GP | Yearly | **[ ]** |
| Review vaccinations – Covid, influenza, pneumococcal | GP | Yearly | **[ ]** |
| Referral to allied health | GP | As required | **[ ]** |
| Complete scripts - physical health medications | GP | As required | **[ ]** |
| Ensure fasting metabolic blood tests are ordered  (HbA1c, Lipids, +/- FBC, EUC, LFTs, Troponin, CRP) | MH Care Coordinator | Yearly3 | **[ ]** |
| Ensure cardiac screening (ECG, echocardiogram) occurs for people prescribed Clozapine or with risk factors | MH Care Coordinator4 | Yearly | **[ ]** |
| Metabolic screening including assessment of blood pressure, weight, waist circumference | MH Care Coordinator | 6 monthly | **[ ]** |
| Arrange ccCHiP referral  [GPs may refer directly: [http://ccchip.clinic](http://ccchip.clinic/)] | MH Care Coordinator | As required | **[ ]** |
| Arrange GP physical health check annually or four weeks post ccCHiP attendance (once report complete) | MH Care Coordinator | Yearly | **[ ]** |
| Ensure mental health medications are prescribed by treating psychiatry registrar / staff specialist | MH Care Coordinator | As required | **[ ]** |
| Ensure lithium levels are taken and copy results to GP | MH Care Coordinator4 | 6 monthly | **[ ]** |
| Send GP a copy of MH Review Module which includes a description of the care team | MH Care Coordinator | Yearly | **[ ]** |

1 MH = MENTAL HEALTH

2 ccCHiP = COLLABORATIVE CENTRE FOR CARDIOMETABOLIC HEALTH IN PSYCHOSIS

3 PLEASE NOTE PEOPLE WITH DIABETES REQUIRE AN ENHANCED LEVEL OF PATHOLOGY SCREENING. PLEASE REFER TO THE DIABETES CYCLE OF CARE FOR MORE INFORMATION

4 CONTINUE CURRENT ARRANGEMENT WHERE GP IS PRESCRIBING & MONITORING CLOZAPINE &/OR LITHIUM

|  |
| --- |
| **All parties agree to:**   * NOTIFY EACH OTHER OF SIGNIFICANT CHANGES IN CONDITION/ TREATMENTS/ STAFF * EXCHANGE HEALTH SUMMARY INFORMATION ANNUALLY (OR AS AGREED). GP: HEALTH SUMMARY, TEAM CARE ARRANGEMENT; MHS: MENTAL HEALTH REVIEW * **COPY PATHOLOGY RESULTS / SPECIALIST REFERRALS BETWEEN GP AND MHS** |