WSSF713 Child Treatment Plan
For children at risk of developing a mental health disorder
MBS Item 44 (40 + mins)
MBS Item 36 (20 + mins)

Wheatbelt GP Network

Child Care Plan for clinical services under ATAPS (Access to Allied Psychological Services). Please complete and fax to **9621 1532**

Patient Details

GP's Name:		Surgery Phone:	
GP's Address:		Post Code:	
Date of Plan:		Surgery Fax:	
Child's Name:		DOB	
Address:		Post code	
Gender:	Male ☐ Female ☐	Is this child in Out of Home Care?	Yes ☐ No ☐
Main language spoken at home	☐ English ☐ Italian ☐ Cantonese ☐ Greek ☐ Mandarin ☐ Arabic ☐ Vietnamese ☐ Other (please specify) …….		
How well does the child speak English?	Very well ☐ Well ☐ Not well ☐ Not at all ☐		
Is the child of Aboriginal or Torres Strait Islander background?	Neither ☐ Aboriginal ☐ Torres Strait Islander ☐ Both ☐ Unknown ☐		

Parent/Carer Details

Name of parent/primary carer			Home phone		
Work phone		Mobile		Preferred contact method	

General assessment

Presenting Problems: Provide a brief description of the child's difficulties and reason/s for referral (e.g. psychological/emotional/behavioural/physical problems, learning difficulties, development issues, social or peer issues, family difficulties, and/or other)

Medical and Developmental History: Provide a brief summary of the child's previous physical and mental health history (including any previous diagnosis and development issues/delays)

Family Medical History: List any serious physical or mental health conditions that family members or relatives are known to have.

Current medication and allergies

Name		**DOB**	

Please provide further information relating to the areas of psycho/social functioning below:

Home and Family (List issues re living arrangements, number of siblings, changes of living, transience, parental separation, custody issues, supervision, out of home care, sibling aggression)

School	Yes □ No □	Name of School		Grade	

Learning issues: (consider: literacy, numeracy, attention/concentration, achievement of potential)	**Social/Behavioural issues:** (Consider peer relationships, social skills, bullying, aggression, attendance, conduct problems)

Eating, exercise, sleep: (Consider nutrition, eating patterns, weight gain/loss, exercise, fitness, energy, sleep)

Safety: (Consider immunisation, domestic violence, bullying, abuse, traumatic experiences, risky behaviour, drug/alcohol use, cigarettes, caffeine)

Mental Status Examination			
Appearance/General Behaviour	□ Normal □ Other	**Mood**	□ Depressed □ Irritability □ Labile □ Mania □ Anhedonia
Thinking (content/rate/disturbances)	□ Normal □ Other	**Affect**	□ Normal □ Blunted □ Flat □ Heightened
Perception (Hallucinations – visual or auditory)	□ Normal □ Other	**Sleep**	□ Normal sleep □ oversleeping □ Initial insomnia □ frequent night waking
Cognition (Level of consciousness/delirium/intelligence)	□ Normal □ Other	**Appetite (**Disturbed eating patterns)	□ Yes □ No
Attention/Concentration	□ Normal □ Other	**Motivation & Energy**	□ high □ low □ normal
Memory (short & long term)	□ Normal □ Other	**Judgement** (ability to make rational decisions)	□ Normal □ Other
Insight	□ Normal □ Other	**Anxiety** (Physical/emotional)	□ Yes □ No
Orientation (time/place/person)	□ Normal □ Other	**Speech** (volume, rate, content)	□ Normal □ Other
Name		**DOB**	

Risk Assessment (If there is immediate risk please contact the INSERT PROVIDERS CONTACT DETAILS			
Suicidal risk	□ Yes □ No	Risk of harm from others	□ Yes □ No

Risk of non-suicidal self-harm	□ Yes □ No	Other child protection concerns	□ Yes □ No

Problem(s)/Action(s)

Problem	Action

Emergency Care Plan (e.g. Family contact person/details)

1		
2		
3	**Acute Mental Health Team**	**Ph:**

I understand the above Care Plan and agree to the outlined actions for my child (child in my care)	
Parent/Carer Signature:	**GP Signature:**