

CHRONIC DISEASE MANAGEMENT- CHRONIC PAIN COMBINED

PREPARATION OF A GP MANAGEMENT PLAN (GPMP) (MBS ITEM NO. 721) & COORDINATION OF TEAM CARE ARRANGEMENTS (TCA) (MBS ITEM NO. 723)

Date these services were provided:	
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Patient's name and address:	
Date of Birth:	
Contact Details:	
Medicare No.	
Private health insurance details, if applicable:	

Existing care plan: notes and outcomes

Other notes or comments relevant to the patient's care planning:

Medications:

Allergies:

Copy of GPMP offered to patient? YES / NO

Copy/relevant parts of the GPMP supplied to other providers? YES / NO / NOT REQUIRED

GPMP added to the patient's records? YES / NO

Review date for this plan: dd/ mm / yy

Patient's Name:

Date:

PREPARATION OF A GP MANAGEMENT PLAN (ITEM 721)			
Patient's health problems / health needs / relevant conditions	Agreed Management goals	Treatment and services required, including Patient actions	Arrangements for treatment/services (when, who, contact details)
Medical	<input type="checkbox"/> Investigate Red flags <input type="checkbox"/> Consider co-morbidities (Diabetes, Obesity, Arthritis, Musculoskeletal disorders, Anxiety, depression, dependence disorder)		
Thoughts and Sleep	<input type="checkbox"/> Set Goals <input type="checkbox"/> Self-management advice and education <input type="checkbox"/> Referral to psychology <input type="checkbox"/> Trial of antidepressants <input type="checkbox"/> Sleep hygiene and strategies		
Medications	<input type="checkbox"/> Set Goals <input type="checkbox"/> Patient medication education <input type="checkbox"/> Monitor benefit/efficacy <input type="checkbox"/> Trial of medication <input type="checkbox"/> Monitor medication adverse effects <input type="checkbox"/> Introduce non-pharmacological strategies		

Physical Activity	<input type="checkbox"/> Set goals <input type="checkbox"/> Appropriate exercise program <input type="checkbox"/> Physiotherapy referral for exercise programme <input type="checkbox"/> Refer to community activity programme		
Lifestyle and Nutrition	<input type="checkbox"/> Set goals <input type="checkbox"/> Diet and lifestyle management advice <input type="checkbox"/> Self-management strategies <input type="checkbox"/> Quit smoking - Medical options /Counselling options <input type="checkbox"/> Safe alcohol use <input type="checkbox"/> Address recreational drug use <input type="checkbox"/> Address social contributors		
Flare up plan	<input type="checkbox"/> Develop Flare up plan <input type="checkbox"/> Identify High risk triggers		

I have explained the steps and costs involved, and the patient has agreed to proceed with the service
 (GP's signature and date)

Patient's Name:

Date:

COORDINATION OF TEAM CARE ARRANGEMENTS (ITEM 723)

Treatment goals for the patient / changes to be achieved	Treatments and services including patient actions	Arrangements for treatment/services (when, who, contact details)
Medical		
<p>Thoughts and sleep</p> <p><input type="checkbox"/> Improve sleep</p> <p><input type="checkbox"/> Learn strategies to manage thoughts</p>	<p><input type="checkbox"/> Practice good sleep hygiene (no coffee after 3pm, same bedtime each night, not read at night, use relaxation technique to go to sleep)</p> <p><input type="checkbox"/> Referral to Psychologist</p>	
<p>Medications</p> <p><input type="checkbox"/> Trial of medication</p> <p><input type="checkbox"/> Plan to taper and cease</p>	<p><input type="checkbox"/> Keep Medication /Pain Diary</p>	
<p>Physical Activity</p> <p><input type="checkbox"/> Start simple exercise program eg. Walk for 10 minutes each day</p> <p><input type="checkbox"/> Do specific exercises each day</p>	<p><input type="checkbox"/> Develop SMART Goals</p> <p><input type="checkbox"/> Activity diary</p> <p><input type="checkbox"/> Physio referral</p> <p><input type="checkbox"/> Enrol in Community exercise program</p>	
Lifestyle and Nutrition		

<input type="checkbox"/> Visit Dietician <input type="checkbox"/> Weight reduction <input type="checkbox"/> Quit smoking <input type="checkbox"/> Safe alcohol use	<input type="checkbox"/> Keep food diary <input type="checkbox"/> Dietician referral <input type="checkbox"/> Use Quit Smoking patches <input type="checkbox"/> Adhere to recommended safe use of alcohol guidelines	
Flare up plan <input type="checkbox"/> Improve management of flare ups	<input type="checkbox"/> Develop upgrade plan <input type="checkbox"/> Develop flare up plan	
<p>Copy of TCAs offered to patient? YES / NO</p> <p>Copy / relevant parts of the TCAs supplied to other collaborating providers? YES / NO / NOT REQUIRED</p> <p>TCAs added to the patient's records? YES / NO</p> <p>Referral forms for Medicare allied health services completed? YES / NO</p> <p>Review date for these TCAs: dd/ mm / yy</p>		

I have explained the steps and costs involved, and the patient has agreed to proceed with the service

(GP's signature and date)