Section 1Introduction

1.1 Client ID _____

1.2 Medicare number documented in medical record

1-Yes 0-No

1.3 Date of Birth / /

1.4 Gender

Male 1
Female 2

1.5 Indigenous status

Aboriginal 1
Torres Strait Islander 2
Both 3
Neither 4
Not stated 5

1.6 Auditor: _____

1.7 Audit Date / /

Section 2 Attendance at health service

2.1 Date of last attendance / /

2.2 If client not seen in last 12 months, is there any record of unsuccessful follow-up attempt since last attendance?

1-Yes 0-No 9-N/A

2.3 Reason last attended

Mental health care 1
Acute care 2
Other 3
Mental health crisis 4

2.4 If Other, state reason:

2.5 First Seen by:

Aboriginal &/or Torres Strait Islander Health Worker 1
Nurse 2
General Practitioner 3
Psychiatrist 4
Psychologist 5
Mental Health Worker 6
Counsellor 7
Other 8
Not stated 9

2.6 Date of last ***Mental Health*** presentation

/ /

Section 3Recording of key health information

*Is there a **documented diagnosis** of*

				Date
3.1	Depressive disorder?	1-Yes	0-No	/ /
3.2	Anxiety disorder?	1-Yes	0-No	/ /
3.3	Other mood disorder?	1-Yes	0-No	/ /
3.4	Psychotic disorder?	1-Yes	0-No	/ /
3.5	Substance use disorder?	1-Yes	0-No	/ /
3.6	Eating disorder?	1-Yes	0-No	/ /
3.7	Mental health disorder secondary to medical cause?	1-Yes	0-No	/ /
3.8	Other disorder?	1-Yes	0-No	/ /

3.9 Is there documented evidence in the notes that the client has been sectioned under the Mental Health Act in the last 12 months?

1-Yes 0-No

3.10 Date of order / /

3.11 Is there a record of the client being in **shared care** in the last 12 months?

1-Yes 0-No

3.12 <u>If no</u>, indicate if there is documentation of **referral** to another health provider for assessment or care in the last 12 months

Mental Health Worker	1
Psychiatrist	2
Psychologist	3
Counsellor	4
Traditional Healer/Indigenous Community Worker	5
Other	6
No referral	7
N/A	9

3.13 Is a current **GP mental health care plan** present (MBS item 2710, 2700, 2701, 2715, 2717)?

1-Yes 0-No

3.14 Is a current **alternative mental health care plan** present?

1-Yes 0-No 9-N/A

If current mental health care plan is present:

3.15 Are **clinical goals** documented?

1-Yes 0-No 9-N/A

3.16 Are **self-management/recovery goals** documented?

1-Yes 0-No 9-N/A

3.17 <u>If goals are recorded</u>, have they been **reviewed** in the last 3 months?

1-Yes 0-No 9-N/A

Section 4Risk factors, co-morbidities and complications

Is there documentation of the following in the last 12 months? (unless otherwise indicated):

4.1 What is the documented smoking status?

Smoker	1
Non-smoker	2
Not stated	3

4.2 If smoker, is it documented that the client has received brief intervention/ counselling for smoking?

1-Yes 0-No 9-N/A

4.3 What is the documented alcohol use?

Higher Risk	1
Low risk	2
Risk level not stated	3
No alcohol use	4
Not stated	5

4.4 If higher risk alcohol use, is there documentation that the client has received brief intervention/counselling for alcohol use?

1-Yes 0-No 9-N/A

4.5 What is the documented drug misuse status?

Current misuse	1
Past misuse	2
Never misused	3
Not stated	4

4.6 If current misuse, is there documentation that the client has received brief intervention/ counselling for drug misuse?

1-Yes 0-No 9-N/A

4.7 Is a BMI documented? 1-Yes 0-No

4.8 What is the documented BMI? [ ]

4.9 If BMI ≥ 25, is there documentation that the client has received brief intervention/ counselling for overweight/obesity?

1-Yes 0-No 9-N/A

*Is there documentation of the following **brief interventions/counselling?***

4.10	Nutrition	1-Yes	0-No
4.11	Physical Activity	1-Yes	0-No

*Is there documentation of the following **co-morbidities and complications** (*on medical/health summary documents*)?*

4.12	Organic complications of alcohol misuse	1-Yes	0-No
4.13	Asthma / COAD	1-Yes	0-No
4.14	Hypertension	1-Yes	0-No
4.15	Type 2 diabetes	1-Yes	0-No
4.16	IHD/AMI	1-Yes	0-No
4.17	Hyperlipidaemia	1-Yes	0-No
4.18	Kidney disease	1-Yes	0-No
4.19	CVA	1-Yes	0-No
4.20	Hepatitis C positive	1-Yes	0-No

Section 5 Audit of current treatment

5.1 Oral antipsychotic medication
1-Yes 0-No

5.2 Oral antidepressant medication
1-Yes 0-No

5.3 Mood stabilizer medication (oral)
1-Yes 0-No

5.4 IM antipsychotic medication
1-Yes 0-No

5.5 Anti-anxiety and hypnotic medication
1-Yes 0-No

5.6 Other psychiatric medication
1-Yes 0-No

5.7 Alternative treatment
1-Yes 0-No

5.8 Use of dosette or webster pack
1-Yes 0-No 9-N/A

Section 6 Hospitalisations and discharge

Number of hospital admissions in last 12 months

6.1 Mental health related admissions ☐

6.2 Other admissions ☐

If any Mental Health related admission/s:

6.3 Is there documented evidence in the medical record of a resolution of the client's mental health disorder on discharge?
1-Yes 0-No 9-N/A

6.4 Is there clear documentation of a discharge letter or follow up plan post discharge?
1-Yes 0-No 9-N/A

Section 7 Scheduled Services

For each service below, indicate if the **most recent** instance of service was delivered by the general health team **OR** the mental health team:

		Delivered by **general health team**			Delivered by **mental health team**		
Comprehensive assessment		**Yes**	**No**	**N/A**	**Yes**	**No**	**N/A**
7.1	Mental health assessment - MSE (mental state examination) (for 3 or more items) *(in the last 6 months*)	1	0	9	1	0	9
7.2	Adult Health Check (MBS item 715) *(in the last 12 months)*	1	0		1	0	
7.3	Alternate Adult Health Check *(in the last 12 months)*	1	0		1	0	
7.4	BP (*in the last 6 months*)	1	0	9	1	0	9
7.5	Review of medication by psychiatrist or registrar *(in the last 12 months)*	1	0		1	0	

		Delivered by **general health team**			Delivered by **mental health team**		
Treatment and care (*in the last 3 months)*		**Yes**	**No**	**N/A**	**Yes**	**No**	**N/A**
7.6	Family and/or individual counselling	1	0	9	1	0	9
7.7	Social issues counselling	1	0	9	1	0	9
7.8	Engagement with family &/or carer/s &/or ally	1	0	9	1	0	9
7.9	Psycho health education of client	1	0	9	1	0	9
7.10	Psycho health education of family &/or carer/s &/or ally	1	0	9	1	0	9

		Delivered by **general health team**			Delivered by **mental health team**		
Cultural engagement (*in the last 3 months)*		**Yes**	**No**	**N/A**	**Yes**	**No**	**N/A**
7.11	Joint discussion/ consultation/ involvement around culturally appropriate service delivery or intervention	1	0	9	1	0	9
7.12	Engagement with Indigenous health worker, traditional healer or Indigenous community worker	1	0	9	1	0	9

Section 8 Investigations

If the client is on regular psychotropic medication is there a record of the following investigations in the last 12 months?

					Date
8.1	LFT (Liver Function Tests)	1-Yes	0-No	9-N/A	/ /
8.2	Serum urea	1-Yes	0-No	9-N/A	/ /
8.3	Serum creatinine	1-Yes	0-No	9-N/A	/ /
8.4	TFT (Thyroid Function Tests)	1-Yes	0-No	9-N/A	/ /
8.5	FBC (Full Blood Count)	1-Yes	0-No	9-N/A	/ /
8.6	Lipid profile	1-Yes	0-No	9-N/A	/ /
8.7	Mood stabiliser (blood level)	1-Yes	0-No	9-N/A	/ /

Section 9 Follow up of abnormal clinical findings

Is there evidence of exacerbation or deterioration of any of the following **symptoms** and/or **behaviours?** *(in the last 12 months)*

9.1	Sleep patterns	1-Yes	0-No
9.2	Hallucinations	1-Yes	0-No
9.3	Mood	1-Yes	0-No
9.4	Psychotic symptoms	1-Yes	0-No
9.5	Medication side effects	1-Yes	0-No
9.6	Aggressive behaviour	1-Yes	0-No
9.7	Social withdrawal	1-Yes	0-No
9.8	Self care	1-Yes	0-No

If ***yes*** to any symptoms or behaviours, is there documentation of the following actions:

9.9 Referral to another health professional

1-Yes 0-No 9-N/A

9.10 Medication adjustment

1-Yes 0-No 9-N/A

9.11 Medication reviewed, but not adjusted

1-Yes 0-No 9-N/A

9.12 Psychosocial/culturally appropriate intervention

1-Yes 0-No 9-N/A