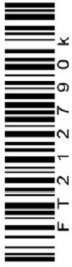


CHIEF CIVIL PSYCHIATRIST APPROVED FORM 7



TREATMENT PLAN

Mental Health Act 2013
Sections 50-53

THCI (Patient ID): _____

Family Name: _____ Given Name: _____

DOB: _____ Gender: M F TG/IT

Address: _____

Phone: _____ Mob: _____

AFFIX STICKER HERE

PATIENT'S HISTORY

Previous diagnoses, presentations, symptoms and duration of these:

Past attempts at treatment and information about previous Orders, and the success or otherwise of these for treating the person's illness:

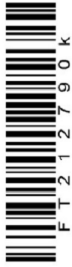
CURRENT PRESENTATION

Current symptoms and duration of these:

Treatment currently being given:

Severity and impact of this presentation on the patient:

CHIEF CIVIL PSYCHIATRIST APPROVED FORM 7



TREATMENT PLAN

Mental Health Act 2013
Sections 50-53

THCI (Patient ID): _____

Family Name: _____ Given Name: _____

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Address: _____

Phone: _____ Mob: _____

AFFIX STICKER HERE

PROPOSED TREATMENT

Proposed medications (including dosage and method of delivery):

Proposed psychological therapies (if any):

Proposed ECT (if any):

Details of any other professional interventions that are proposed (blood tests, x-rays etc):

Proposed treatment setting or settings (including whether detention in an approved hospital is required or likely to be required):

CHIEF CIVIL PSYCHIATRIST APPROVED FORM 7



TREATMENT PLAN

Mental Health Act 2013
Sections 50-53

THCI (Patient ID): _____
Family Name: _____ Given Name: _____
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Address: _____
Phone: _____ Mob: _____

AFFIX STICKER HERE

TREATMENT THE PATIENT IS TO RECEIVE

Details of anticipated treatment outcomes including how the proposed treatment is expected to impact on the patient's current presentation:

[Empty text box for treatment outcomes]

Details of any side effects associated with the treatments that are proposed in this plan:

[Empty text box for side effects]

CONSULTATION

Has the patient been consulted in the preparation of this plan? Yes No

Details of the patient's views about the treatments that are proposed in this plan, including any objections:

[Empty text box for patient's views]

Has anyone else been consulted in the preparation of this plan? Yes No

Details of the views of other people consulted in the preparation of the plan, about the treatments that are proposed in the plan:

[Empty text box for other people's views]

ENDORSEMENT AND DURATION OF THIS PLAN

Medical Practitioner name: _____ Signature: _____

Date and time plan prepared: Date: _____ Time: _____

CHIEF CIVIL PSYCHIATRIST APPROVED FORM 7



TREATMENT PLAN

Mental Health Act 2013
Sections 50-53

THCI (Patient ID): _____

Family Name: _____ Given Name: _____

DOB: _____ Gender: M F TG/IT

Address: _____

Phone: _____ Mob: _____

AFFIX STICKER HERE

I have:

- provided a copy of the plan to the patient and explained the plan to the patient in a language and form that the patient can understand
- provided a copy of the plan to the Chief Civil Psychiatrist
- provided a copy of the plan to the Mental Health Tribunal
- placed a copy of the plan on the patient's clinical record
- made a note in the patient's clinical record to the effect that these actions have been completed.

CONTACT DETAILS:

Mental Health Tribunal: Phone: (03) 6165 7491 Email: mht.applications@justice.tas.gov.au

CCP: Phone: (03) 6214 5716 Fax No: (03) 6230 7739 Email: chief.psychiatrist@dhhs.tas.gov.au

THIS PLAN CEASED ON DATE: _____

THIS PLAN HAS BEEN SUPERSEDED BY A NEW PLAN DATED: _____