MENTAL HEALTH SHARED CARE PLAN __ /__ /__

Name		Date of Birth	
General Practitioner		GP Practice	
MH[1] Care Coordinator		MH Team	

Task	Responsible	How Often	Completed
Physical health check: Pulse, BP, weight, waist circumference (unless provided by MH[1] 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 ccCHiP[2] 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	Yearly[3]	☐
Ensure cardiac screening (ECG, echocardiogram) occurs for people prescribed Clozapine or with risk factors	MH Care Coordinator[4]	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]	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 Coordinator[4]	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**