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| **Health Support Plan: Mental Health** |
| **Participant Name:** | **DOB**:  |
| **Plan Date:** | **Review Date due:** |
| **Plan approved by** (mental health professional or GP): Name:Sign:Date: |
| **Psychiatrist name:**  |
| **Mental Health Case Worker name:** |
| **Community mental health service:**  |
|  |
| **Current diagnosis:**  |
| **Date of original diagnosis of current condition:**  |
| **Original diagnosis made by:**  |
|  |
| **Specific alerts about medication prescribed for this illness** e.g. common side-effects, risks, food, drinks and other medications that must not be combined. |
| **Any other relevant information:** |
| **How would you like to be supported during this process?**  |
| **When I am …** | **What this looks like, what you’ll observe** | **Action – what you must do** |
| Well |  | Positive interactions |
| Becoming unwell |  | Monitor & document in notes |
| Unwell |  | Monitor may need to make appts |
| Very unwell |  | Make Dr appt ASAP |
| **What to tell my mental health professionals** e.g.my triggers, and positive strategies/interactons |
| **Triggers:****Positive Strategies/Interactions****Please be sure to make note of any specific ‘script’ or information that must be conveyed to assist access and support.For example: “DO NOT USE THE WORD BEHAVIOUR. Instead, say signs/symptoms.”**State what the person is like when well and why you think they are becoming unwell using the relevant descriptions provided in this plan.State any prior actions taken (for example PRN meds <name of drug> administered at <time administered> |
| **If medical assistance is required, please contact**  |

Participant / Nominee Signature:

Date:

**PARTICIPANT NAME**:

**PLAN DATE**:

# **Staff acknowledgement**

I have read and understood the Mental Health Support Plan for this participant.

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| **#** | **Worker Name** | **Worker Signature** | **Date** |
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