**<< name of practice>>: << date>>**

GPMP (item 721) - TCA (item 723)

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **PATIENT:** | |  | **PATIENT'S USUAL GP:** | |
| Name: | ***Patient Demographics.Full Name*** |  | Name: |  |
| Address: | *Patient Demographics.Full Address* |  | Address: |  |
| DOB: | *Patient Demographics.DOB* |  | Telephone: |  |
| Telephone: | *Patient Demographics.Phone (Home)* |  | **DETAILS OF PATIENT'S CARER** (if applicable) | |
| Medicare No: | *Patient Demographics.Medicare Number* |  |  |  |
| Private Health Insurance: | *MERGEFIELD BLANK* |  |  |  |
| **Patient Agreement for Assessment and Management Plan to Proceed** | | | | |
| **It has been explained to me the purpose of this assessment and I/my carer give permission to discussion my medical history/diagnosis with other service providers as appropriate. All information will be confidential.**  **Has patient agreed? □ YES** | | | | |
| **PAST MEDICAL HISTORY** | | | | |
| **Current Problems:**  *<<Clinical Details.Problem List (Current) With Comments>>* | | | | |
| **FAMILY HISTORY** | | | | |
| *<<Clinical Details.Family History>>* | | | | |
| **MEDICATIONS:** | | | | |
| *<<Clinical Details.Medication List>>* | | | | |
| **ALLERGIES:** | | | | |
| *<<Clinical Details.Allergies>>* | | | | |
| **IMMUNISATIONS** | | | | |
| *<<Clinical Details.Immunisation List>>* | | | | |
| **DRIVING:**  **DOES THIS PATIENT HAVE A CURRENT MEDICAL CERTIFICATE FOR DRIVING?**  **□ YES □ NO □ Not Applicable** | | | | |

**Summary about this patient’s status and needs:**

**<<name of patient>> lives with the conditions listed in current problems. This management plan takes these into account however will prioritise OSTEOPOROSIS as the chronic disease most likely to impact on function and morbidity threatening independence.**

***GOALS :***

Falls prevention, prevent progress of bone loss and osteoporosis, maintain function and ADL's

***ACTIONS***

|  |  |  |  |
| --- | --- | --- | --- |
|  |  | **Action** | **Expected Outcome and who is responsible** |
| **A** | ADLS - managing |  |  |
|  | AHP which are involved.   * Podiatry * EP * Dietitian * Optometrist * Physio * Dentist * Occupational Therapist | Footwear, balance  Osteogenic exercises  Calcium rich diet  Vision and depth re falls prevention  Falls prevention, hip flexor strength.  Dental status and extractions when on treatment  Home safety and falls prevention. |  |
|  | Activity | General activity  Purposeful activity |  |
| **B** | BP |  |  |
|  | BP postural changes |  |  |
|  | Body Changes  BMD: In date ?  Height change  Kyphosis | Yes  No  Yes  No |  |
| **C** | Calcium intake :-  Insure 3 serves calcium rich foods per day |  |  |
| **D** | Drugs/Medications for OP | Insure medication adherence.  Consider DMMR |  |
|  | Vitamin D Level (winter)  Is Vitamin D Replacement Necessary |  |  |
|  | Doctor visits | Insure regular review at least every 3 to 6 months |  |
|  | Dental Review every 6 months |  |  |
|  | Dental extractions | Explain impact of OP and extractions. Therapy and timing of extractions |  |
|  | Distress/depression with OP | Monitor for distress with functional change and burden of disease |  |
| **E** | Eyes | Ensure eye health review as contributor to fall prevention |  |
|  | Exercise – | Confirm that osteogenic exercise and falls prevention is actioned. Connect patient with falls prevention programmes |  |
|  | Education | Nurse revisits diagnosis, diet and falls every review |  |
| **F** | Feet and Footwear | Safe  At risk |  |
|  | Foot review by Pod | <12 months  >12 months (arrange review)  Never (arrange review) |  |
|  | Have there been any falls in last 3 to 6 months |  |  |
| **'S** | Symptoms of complications including pain |  |  |
|  | Safety Home |  |  |
|  | Secondary causes of OP (do they need to be excluded?) | Yes  No |  |
|  | Specialists involved |  |  |

**TEAM CARE**

|  |  |  |  |
| --- | --- | --- | --- |
| **Team Member** | **Name** | **Contribution** | **Expected Outcome** |
| Pharmacist |  | DMMR  Contacted: | Optimise medication adherence, decrease interactions, Reduced medication contribution to falls. |
| EP |  | Assessment, individual EP programme – osteogenic exercises  Contacted: | Prevent fall, improve and increase, strength, endurance. Maintain functionality and independence |
| Podiatrist |  | Foot care, Foot wear education  Contacted | Reduce falls through edication and footwear optimisation |
| Physio |  | Falls and balance assessment  Contacted | Fall prevention |
| Optometrist |  | Eye health review  Contacted: | Prevent loss of vision - maintain independence, |
| Occupational Therapist |  | Home assessment  Contacted | Improved home safety, reduced falls |
| Dentist |  | Optimise dental health | prevent peri-odontal disease to prevent on complications |
| Dietitian |  | Optimise diet and Calcium intake  Contacted: |  |
| Practice Nurse |  | Care Coordination  Education |  |
|  |  |  |  |
| Specilaist |  |  |  |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Copy of CDMP offered to patient? | <<yes>> <<no>> |  | CDMP added to the patient's records? | <<ye>> <<no>> | |
|  | | | | | |
| Copy/relevant parts of Management Plan supplied to other providers? | | | | | <<yes>> <<no>> |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Date service was completed: | << date>> |  | Proposed Review Date: (Recommended 3-6 months) | Enter date |

|  |  |  |  |
| --- | --- | --- | --- |
| I have explained the steps and costs involved, and the patient has agreed to proceed with the service. | | | |
| GP's Signature: | ................................................................................................................. | Date: | Misc<<date>> |