**<< 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.**

|  |  |  |  |
| --- | --- | --- | --- |
| ***Patients Health Problems/ Health Needs/ Relevant Conditions*** | ***Management Goals with Which Patient Agrees*** | ***Treatment and Services Required Including Action to be Taken By Patient*** | ***Arrangements for providing treatment/services - when, who, contact details*** |
| ***OSTEOPOROSIS*** | Falls prevention, prevent progress of bone loss and OP, maintain function and ADL's | ***Ensure adequate calcium intake in diet and if unable to achieve this supplement with calcium*** | ***GP to coordinate***  ***Dietitian***  ***Patient*** |
|  |  | ***Ensure Vitamin D levels are replete*** | ***GP***  ***Patient*** |
|  |  | ***Maintain function and ADL’s*** | ***Patient***  ***Physio*** |
|  |  | ***Ensure home safety.*** | ***GP to coordinate***  ***OT*** |
|  |  | ***Falls prevention through footwear safety.*** | ***Podiatry*** |
|  |  | ***Prevent bone loss through appropriate anti-resorptive therapy and regular review by GP (BMD, pathology)*** | ***GP*** |
|  |  | ***Falls prevention through osteogenic exercise programmes*** | ***GP to coordinate***  ***EP*** |
|  |  | ***Prevent falls through medication optimisation and monitor anticholinergic load and hypotension*** | ***GP***  ***Pharmacy*** |
|  |  | ***Ensure patient engagement and commitment through education*** | ***Practise Nurse*** |
| ***ADD OTHER CHRONIC DISEASE ISSUES HERE*** | ***ADD GOALS FOR OTHER CHRONIC DISEASE HERE*** |  |  |

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, Footwear education  Contacted | Reduce falls through education 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>> |