Hepatitis C Care Plan

GP Management Plan (**MBS item 721**) and Team Care Arrangement where applicable (**MBS item 723**) - refer to [www.mbsonline.gov.au](http://www.mbsonline.gov.au)

**Health professionals:** for assistance with preparation of the GPMP and/or TCA, contact [gillian.cass@nwmphn.org.au](mailto:gillian.cass@nwmphn.org.au) or (03) 9347 1188.

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| **Patient name:** | |
| Patient Date of Birth: | Usual GP: |
| Medicare and/or private health insurance: | Practice name: |
| Patient address: | Practice address: |
| Patient phone: | Practice phone: |
|  | |
| Carer name (if applicable): | Carer phone: |
|  | |
| If the patient has a previous or existing plan, when was it prepared and what were the outcomes? | Notes or comments relevant to the patient’s care planning: |
|  | |
| **Medications**: | **Allergies**: |
| 🗆 Copy of plan offered to patient. 🗆 Copy / relevant parts of the plan supplied to other providers (as required). 🗆 Copy of plan added to the patient’s records.  🗆 Referral forms for Medicare allied health completed – if relevant. [For referral forms call 1800 067 307 or go to [www.health.gov.au/mbsprimarycareitems](http://www.health.gov.au/mbsprimarycareitems)]  Date service was completed: ………………………………………….……………………… Review Date: ………………………………………………………………………...............… | |

**Name**:......................................................................................…………… …………… **Date**: ………………………………………………………

My GP has explained the steps and costs involved and I have agreed to proceed with the service. I have also agreed to the involvement of other health providers and to share clinical information unless specified below: ……….......……………………………….…………………………………………………………………………………………………

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| My Care Plan(GP Management Plan & Team Care Arrangement) | | | | | |
| **My problems / needs / concern / issue** | | | **My goals** *(what’s important to me)* | **My proposed actions** | |
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|  | | |  |  | |
| Who Will Help Me? | | | | | |
| **Who** | **Details** | **How will they help me?** | | | **Appointment Date & Time** |
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EXAMPLE ONLY

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| My Care Plan(GP Management Plan & Team Care Arrangement) | | | | | |
| **My problems / needs / concern / issue** | | | **My goals** *(what’s important to me)* | **My proposed actions** | |
| **I need to take medication every day to cure hepatitis C.**  **I need to have some tests throughout my hepatitis C treatment.** | | | I want to be able to work and live without having to worry about hepatitis C.  I want to get rid of the disease and be cured.  I want to make sure I am healthy during my hepatitis C treatment. | I will set a reminder on my phone and I will stick a note on my fridge/coffee maker so I am reminded about my medications when I eat my breakfast.  I will make sure I have reminders of my appointments for other tests. | |
| **I drink alcohol / I inject drugs / I smoke cigarettes.** | | | I would like to cut back on the alcohol I drink so I can look after my liver and health better / I will have clean ‘fits’ around for when I use drugs so that I don’t get hepatitis C again or pass it on to anyone else /  I want to save the money I spend on cigarettes or drugs. | I will only have … drinks a day instead of …. / I will replace … drinks a day with a soda with lime / I will go to my local Needle and Syringe Program or pharmacy (specify site) to stock up on ‘fits’ every …days/weeks / I will set a reminder in my phone so that I remember to collect the injecting equipment I need /  I will try to make a pack of cigarettes last longer and smoke less each day. | |
| **I want to be more fit / exercise more / lose weight.** | | | I want to be able to keep up at work / spend time with the family / play more sport again. | I will walk the dog every day / I will walk 2,4 or 6 blocks a day around my house / I will talk to the dietician. | |
| Who Will Help Me? | | | | | |
| **Who** | **Details** | **How will they help me?** | | | **Appointment Date & Time** |
| GP | Dr...  (03) xxxx xxxx | They will check how my treatment is going, arrange blood tests and write scripts. The office will ring to remind me to come in for repeat scripts and tests. | | |  |
| Mental health worker (*e.g.* Counsellor, Mental Health Nurse, Psychologist, Case Coordinator) | Mr/Ms…  (03) xxxx xxxx  Or 04xx xxx xxx (emergencies only) | They will help with my mental health care and what to do when I am feeling …. | | |  |
| Needle and Syringe Program (NSP) | Mr/Ms…  (03) xxxx xxxx | I will go there to collect ‘fit packs’ and clean injecting equipment every …. | | |  |
| Dietician | Mr/Ms...  (03) xxxx xxxx | They will help me get organised with food and nutrition, and help me learn to prepare healthy meals for myself. | | |  |
| Hepatitis Victoria | Infoline  (03) xxxx xxxx | They will be able to answer any questions I have about hepatitis and treatment, and can link me with peer support and more information. | | |  |