



**Queensland
Government**

**Mental Health Services
Care Plan**

(Affix identification label here)

URN:

Family name:

Given name(s):

Address:

Date of birth:

Sex: M F I

Facility:

Instruction: this Care Plan must be informed by risk management strategies outlined in the risk screen; outcome measures; and consumer's recovery plan

Mental Health Act status

- | | | | |
|---|---|--|---|
| <input type="checkbox"/> None | <input type="checkbox"/> Forensic order (mental health) | <input type="checkbox"/> Treatment support order | <input type="checkbox"/> Transfer recommendation |
| <input type="checkbox"/> Examination authority | <input type="checkbox"/> Forensic order (disability) | <input type="checkbox"/> Person AWA (interstate) | <input type="checkbox"/> Classified (involuntary) |
| <input type="checkbox"/> Examination/judicial order | <input type="checkbox"/> Forensic order (criminal code) | <input type="checkbox"/> Recommendation for assessment | <input type="checkbox"/> Classified (voluntary) |
| <input type="checkbox"/> Treatment authority | | | |

Conditions of order:

Does the consumer have an Advance Health Directive? Y N UK **An interpreter was used**

Date risk screen completed: _____ **Date AOD assessment completed:** _____

Clinical goal 1

Aligns to recovery goal

Strategies, interventions and involvement of other service providers	Person/service responsible	Target date

Clinical goal 2

Aligns to recovery goal

Strategies, interventions and involvement of other service providers	Person/service responsible	Target date

Clinical goal 3

Aligns to recovery goal

Strategies, interventions and involvement of other service providers	Person/service responsible	Target date

Clinical goal 4

Aligns to recovery goal

Strategies, interventions and involvement of other service providers	Person/service responsible	Target date

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