

DEPOT GP SHARED CARE (LAI) REVIEW FEEDBACK FORM

Fax: 07 3078 2120

(V1, July 2024)

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RE Patient Name:

DOB:

GP Name:

Practice:

Examination Date:

Ethnicity:

Is an interpreter required:

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Consider longer appointments for 6 monthly & annual reviews

PHYSICAL ASSESSMENT

Physical Assessment Performed:

General Health Check inc. Blood Pressure & Weight:

Assess for any adverse side effect from LAI medication:

Please note any abnormalities in the additional comments section below and treat as appropriate. Report any medication changes

BRIEF MENTAL STATE ASSESSMENT EVERY 28 DAYS & EACH REVIEW

Brief Mental State Assessment Results: <Brief Mental State Assessment every 28 days and each review>

Please report any notable deterioration in mental state to <Name and phone number of relevant MSAMHS team>.

After hours enquiries can be directed to MH CALL 1300 64 22 55

DEPOT ADMINISTRATION

Depot administered:

Name of medication administered:

Dose:

Given by:

Site administered:

Appointment made:

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6 MONTHLY METABOLIC SCREENING

Please report any abnormalities to <Name and number of relevant MSAMHS team> and treat as appropriate

Height :

Fasting Blood Glucose:

Lipids:

LFT:

U and E:

Referral to Dietitian:

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6 MONTHLY MEDICATION REVIEW

Current Medications:

RE:

D.O.B:

Annual Home Medicine Review:

ANNUAL CARDIAC SCREENING

(Please report any abnormalities to <Name and number of relevant MSAMHS team>and treat as appropriate)

Date of ECG:

Result:

Date of Echocardiogram:

Result:

ADDITIONAL COMMENTS

COMPLETION INSTRUCTIONS:

RE:

D.O.B: