

Crestwood Family Practice

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Dr Thashangan Murugathas

Provider No: 4929029Y

ABN: 76212028671

15/03/2024

Michelle Hookham
Old Hawkesbury Hospital
6 Christie St
Windsor
NSW 2756
Phone: 02 4577 4435
Mobile: 0423 162 001
Email: health@michellehookham.com.au

Dear Michelle,

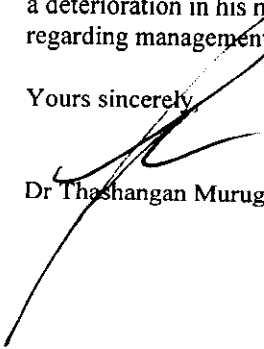
Re: Mr David Best DOB 11/03/1968

PO Box 473 Richmond 2753

Home: Mobile: 0497799207

Thank you for seeing David. David unfortunately suffered a motorbike accident on 23/01/23 and sustained a right grade 3 open trimalleolar ankle fracture. This required multiple surgeries with orthopaedics and plastics at John Hunter hospital including fibula fixation as well as ankle debridement and RFFF reconstruction with left radial forearm flap. I then referred to him to Dr Mayuran Suthersan (orthopaedic surgeon) who did removal of fibular plate and screws, tenolysis of his peroneus longus and brevis tendon and fixation of his posterior tibial non-union on 30/06/23. Unfortunately David suffered another setback when the ankle got infected over the Christmas period and he required IV antibiotics at Hawkesbury Hospital. Dr Suthersan has advised David is suffering from progressive post-traumatic arthritis which appears to be deteriorating quickly. His has also advised he will likely require ankle arthrodesis surgery in the future. As a result of this he will likely be permanently disabled for the future. He is on regular opiate medication to manage his pain. This has all understandably led to a deterioration in his mental health with symptoms of anxiety and depression. I would appreciate your assessment and opinion regarding management. I have attached his GPMHCP and refer him for an initial 6 sessions.

Yours sincerely



Dr Thashangan Murugathas

GP MENTAL HEALTH CARE PLAN

Item No: 2715 (Assessment & Plan)

Step 1 - Patient Assessment

Patient Name:	Mr David Best 2608 George Street South Windsor 2756	Outcome Tool K10	Result 35
DOB:	11/03/1968	Gender:	Male
Date:			15/03/2024
Referring GP Details:	Name: Dr Thashangan Murugathas Practice: Crestwood Family Practice Provider No: 4929029Y		

Problem/Diagnosis	the GP must document a mental disorder in the Plan.
Number 1:	Mixed anxiety and depression

Medications	
Advantan 0.1% Cream Azelastine /Fluticasone 125mcg;50mcg/spray Nasal Spray Cefalexin 500mg Capsule Celebrex 200mg Capsule Fluticasone /Salmeterol 250mcg;25mcg Inhaler Lipitor 20mg Tablet Lyrica 75mg Capsule Mupirocin 2% Cream Oxycodone 5mg Tablet Perindopril/Amlodipine 10mg; 10mg Tablet Salbutamol CFC-Free 100mcg/dose Inhaler Sildenafil 100mg Tablet Targin 10mg; 5mg Modified release tablets	Apply to affected area twice a day for 7 days. Take for 7 Days. 1 puff each nostril Daily. 2 capsules twice a day for 5 days. Take for 5 Days. 1 Capsule Daily. 1 puff Twice a day p.r.n. 1 Tablet In the evening. 1 tablet twice a day. Take for 28 Days. Apply to affected area 2-3 times per day. Three times a day p.r.n. 1 tablet QID PO if required - no driving or operating heavy machinery. 1 Tablet Daily. 4 puffs Three times a day p.r.n. with a spacer. 1/4 Three times a day. 1 tablet twice a day.

Past History
1. Anxiety 2. Depression

Mental Health History/Treatment
Has the person ever received specialist mental health care? Yes Other Relevant Information: Language spoken at home: English How well does the person speak English: Very well

Family History

Social History
Occupation: Unemployed due to injury Alcohol: 3 drinks/day 3 days per week. beer Previously moderate from 1984 Smoking: Ex moderate smoker from 1982 until 2005 Smoke 5-10 cigarettes a day

Allergies
Desvenlafaxine Tramadol

Personal History/Lifestyle Issues (eg childhood, substance abuse, relationship history, coping with previous stressors)

Stressors: David unfortunately suffered a motorbike accident on 23/01/23 and sustained a right grade 3 open trimalleolar ankle fracture. This has resulted in multiple surgeries and then complicated by infection. He now suffers with chronic pain and permanent disability as a result of the injury.

Relevant Physical and Mental Examination

NAD

Investigations

Nil

Mental Status Examination	
Appearance and General Behaviour <input checked="" type="checkbox"/> Normal <input type="checkbox"/> Other:	Mood (Depressed/Labile) <input type="checkbox"/> Normal <input checked="" type="checkbox"/> Other: 'Placid and happy, down at times'
Thinking (Content/Rate/Disturbances) <input checked="" type="checkbox"/> Normal <input type="checkbox"/> Other:	Affect (Flat/blunted) <input checked="" type="checkbox"/> Normal <input type="checkbox"/> Other:
Perception (Hallucinations etc.) <input checked="" type="checkbox"/> Normal <input type="checkbox"/> Other:	Sleep (Initial Insomnia/Early Morning Wakening) <input type="checkbox"/> Normal <input checked="" type="checkbox"/> Other: Initial insomnia
Cognition (Level of Consciousness/Delirium/Intelligence) <input checked="" type="checkbox"/> Normal <input type="checkbox"/> Other:	Appetite (Disturbed Eating Patterns) <input type="checkbox"/> Normal <input checked="" type="checkbox"/> Other: Up and down
Attention/Concentration <input type="checkbox"/> Normal <input checked="" type="checkbox"/> Other: Impaired	Motivation/Energy <input type="checkbox"/> Normal <input checked="" type="checkbox"/> Other: Reduced
Memory (Short and Long Term) <input type="checkbox"/> Normal <input checked="" type="checkbox"/> Other: Short and Long Term	Judgement (Ability to make rational decisions) <input checked="" type="checkbox"/> Normal <input type="checkbox"/> Other:
Insight <input checked="" type="checkbox"/> Normal <input type="checkbox"/> Other:	Anxiety Symptoms (Physical & Emotional) <input type="checkbox"/> Normal <input checked="" type="checkbox"/> Other: Emotional
Orientation (Time/Place/Person) <input checked="" type="checkbox"/> Normal <input type="checkbox"/> Other:	Speech (Volume/Rate/Content) <input checked="" type="checkbox"/> Normal <input type="checkbox"/> Other:

Risk Assessment			
Suicidal Ideation	Nil acute	Suicidal Intent	Nil
Current Plan	Nil	Risk to Others	Nil

Key Family/Support Contact Ken Hawes - 0421727535

FORMULATION

Main Problems/Diagnosis
(Risk/protective factors)

Risk factors: isolation / chronic pain

Other Mental Health Professionals Involved in Patient Care	
Name/Profession:	Contact Number:
Michelle Hookham	0423 162 001

Patient Education Given?	
Mental Health Link (24 hour support service)	1800 011 511
Suicide Call Back Service	1300 659 467 www.suicidecallbackservice.org.au
GP Psych Support	1800 200 588

Step 2 - Mental Health Care Plan

Patient Name: Mr David Best
2608 George Street
South Windsor 2756

Problem/Diagnosis	Goal (eg reduce symptoms, improve functioning)	Action/Task (eg psychological or pharmacological treatment, referral, engagement of family and other supports)
Number 1: Mixed anxiety and depression	Reduce symptoms Improve mood Prevent deterioration Manage chronic pain	Psychologist review

Emergency Care/Relapse Prevention GP review + Psychiatrist review

Patient Education given: Yes **Key family contact/support details/phone:**
Copy of MH Plan given to patient: Yes Ken Hawes - 0421727535

Initial Action Plan - to be considered for: Taking into account the issues that you and the patient have identified, summarise the initial action suggested (Highlight appropriate tick box and type an "x")

- ☒ Diagnostic assessment
 ☐ Psycho-education
 ☐ Interpersonal Therapy
- ☒ Cognitive Behavioural Therapy (CBT)
- ☐ Behavioural interventions
 ☐ Relaxation strategies
- ☐ Cognitive interventions (specify)
 ☐ Skills training
- ☐ Other CBT interventions (specify) :
- ☐ Other (specify):

Review Date:
(Add a Recall in MD for 1-6 months after the Plan date) 15/09/24

Record of Patient Consent

I, DAVID BEST, (patient name - please print clearly)
Consent to this Care Plan to proceed and I agree to information about my mental health being recorded in my medical file and being shared between the GP and the counsellor(s) to whom I am referred, to assist in the management of my health care.

Signature (patient): _____ Date: 15/03/24

I (GP) have discussed the proposed referral(s) with the patient and am satisfied that the patient understands the proposed uses and disclosures and has provided their informed consent to these.

GP Signature _____ T. Murugathas _____ 15/03/24
GP Name Date

Referring GP Details: Name: Dr Thashangan Murugathas
Practice: Crestwood Family Practice
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