MOSTYN STREET CLINIC

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GP MANAGEMENT PLAN / TEAM CARE ARRANGEMENTS - MBS ITEM No. 721 /723 (Asthma)

Date Prepared: 15/04/2025 **Proposed review date:**
Date Reviewed:
Date Reviewed:
Date Reviewed:
Has patient completed GPIS survey? (Y/N) https://forms.office.com/r/VzFu8458mV
Has patient been added to GPIS spreadsheet? (Y/N)

Patient Details	GP DETAILS
Ms Megan Elizabeth Tudor 20 Johns Road Maldon 3463	Dr Louisa Hope 11 Mostyn Street CASTLEMAINE 3450 0645644X

Patient's Story and Values
Has a history of asthma and feels it is less predicatable. Is using her ventolin/seretide every second day at present. Once or twice. Takes antihistamine and nasonex. **Has a current referral in to ENT and Pulmonary Rehab**

Current Problems List

1955	Asthma	since childhood-lot of steroids, flared after menopause
2013	Sinusitis	severe sinusitis-ENT discovered malformation in left sinuis
2013	postnasal drip	aggravates the asthma
18/04/2023	Subclinical hypothyroidism	thinks from iodine in Bonsoy milk- TSH=6.7, T4 14.5 on thyro balance from Metagenics not Hashimotos apparently per specialist
05/06/2023	Osteopaenia	
20/02/2024	Granuloma annulare	
27/03/2025	Advanced care directive	Wants CPR and initial resuscitation but not life support if outcome is expected to be poor

Resolved Problems List

Not recorded.

Current Medications

Advantan 0.1% Cream	apply Before bed.
Fexofenadine 180mg Tablet	1/2 Daily.
Nasonex 50mcg/dose Nasal Spray	2 Spraies Daily.
Seretide MDI 250 /25 250mcg;25mcg/dose Inhaler	1 Inhalation Before bed.
Ventolin CFC-Free with counter 100mcg/dose Inhaler	2 puffs p.r.n.

Allergies

STELAZINE	lockjaw after eating cheese

NYSTATIN swelled up

Immunisations

10/04/2023 FLUAD QUAD

Smoking status / history
Non smokerNon smoker
Social History:
Occupation: No occupation given.

Smoking:
Non smoker

Observations:

Date of Confirmed Diagnosis of Asthma **Co-existing COPD** yes / no

Snapshot:

	Date	
Post bronchodilator Spirometry (at either initial diagnosis or first available spirometry after diagnosis)		FEV_1/ FVC = Has had 3 times in her life. Has said she prefers not to have again. Lung function was 60% last time. FEV_1 = predicted %
CXR		Not for some time
Pulmonary Rehab		Has a current referral
Last Pneumococcal vaccination		Next due / or now complete
Last influenza vaccination		2025

Last BMD T score hip / spine		Osteopenia 2023
Hospitalisations in last 12 months		No
ICU admission for Asthma ever?		No

Biomedical data	**Initial GPMP Date**	**Review GPMP Date**	**Review GPMP Date**
Exacerbations in last year			
FEV_1/ FVC (post bd)			
FEV_1 (post bd)			
FEV_1 % pred (post bd)			
SaO_2 (if applicable)			
Depression score K10/DASS21 /HADS/GDS			
Smoking status	Non		
Inhaler technique	Satisfactory		
Action plan review			

Resources:
https://asthma.org.au/support/how-we-can-help/

https://asthma.org.au/about-asthma/asthma-attacks/

Asthma Australia 1800 645 130
Puff the magic dragons- Lung disease support group in Castlemaine (1800 654 301)
Castlemaine Pulmonary rehab and options https://lungfoundation.com.au/services/castlemaine-health/

Patient problems / needs / relevant conditions	Goals and Recommendations	Recommended treatments and services including patient actions	Arrangements for treatments/services (when, who, contact details)
1. General			
Patient's understanding of asthma	Patient to have a clear understanding of asthma and the patient's role in self-management.	Ongoing asthma education by GP/Nurse during regular reviews Resources available from: National Asthma Council Asthma Australia	GP Nurse
Minimise symptoms	Absent or minimal symptoms No nocturnal or early morning symptoms. Minimal exertional cough or wheeze. Absent or minimal reliever medication use (less than 3 times a week except with exercise).	GP/Nurse to assess asthma severity when patient is stable (use Asthma control questionnaires) and individualise treatment. Patient to keep symptom diary or PEFR diary. Patient to adhere to preventer medication routine. Patient to take continuing responsibility for their asthma and attend for regular review.	Has a current Action Plan

Self-management skills	Patient in control of their asthma. Patient is able to recognise early signs of deterioration in asthma and respond appropriately. Patient knows when to and how to obtain prompt medical attention	GP/Nurse to provide a written asthma action plan and rehearse with patient. Patient to use asthma action plan and have it reviewed regularly Patient given written phone number for the GP surgery and out of hours number. Action plans available from: https://www.nationalasthma.org.au/living-with-asthma/asthma-action-plans	
2. Lifestyle			
Nutrition	To eat a balanced diet and maintain a healthy weight	Consider referral to dietician if BMI low or high Frequent small meals can assist dyspnoea Resources available from: National Health and Medical Research Council	Patient to implement GP/Nurse to monitor Dietitian
Weight **Your weight** **BMI** **Waist**	Your target:	Monitor Review 6 monthly	Patient to monitor GP/Nurse to review
Physical Activity Current Physical activity	Your target:____	Patient to implement exercise routine	GP/practice nurse to monitor.

	Ideal: At least 30 minutes walking or equivalent 5 or more days per week If exercise induced asthma, patient to take reliever medication 5-10 minutes before exercise	Resources available from: National Physical Activity Guidelines Exercise group Better living with exercise booklet https://lungfoundation.com.au/resources/better-living-with-exercise-booklet/	Pulmonary Rehabilitation Programme current referral Referral to Chronic Disease Self-Management Programs Exercise Physiologist
Smoking **Cigarettes/day:** **Pack years:**	Complete cessation	Smoking cessation strategy: Consider: - Quit Quit Smoking & Vaping: Get Expert Cessation Tips & Help | Quit - Medication - Lung Age estimator and pack years calculator http://lungfoundation.com.au/health-professionals/clinical-resources/copd/primary-care-respiratory-toolkit/ Behavioural support/counselling	N/A
Alcohol Current Alcohol Consumption	Low risk alcohol consumption. Your target:____ standard drinks per day	Reduce alcohol intake Resources available from: https://www.nhmrc.gov.au/about-us/news-centre/reducing-health-risks-drinking-alcohol	Occassional
3. Medication			
Optimise medication	Optimise medication to	GP to supervise step down of medication after	uses spacer for

program	give lowest possible dose that controls asthma and symptoms. No side effects or minimum side effects from medications Optimise lung deposition of asthma medications	effective control in place for 6-12 weeks GP/Nurse to organise regular spirometry Patient agree to return for planned review even when feeling 'well' Use of spacer to give optimal inhaled medication if applicable. Education given regarding use and care of spacer Inhaler device education and assessment (taking into consideration arthritis)	inhalers, happy with technique Home Medication Review (Accredited pharmacist)
Immunisation	Yearly influenza vaccination recommended Pneumococcal vaccine if eligible	Check annually	Is having Flu vaccine this week
4. Biomedical			
Blood pressure **Your BP:**	Your target: Ideal: < 130/80 mm Hg	Check every 6 months	GP Nurse
Family / Carer support (Delete if not relevant)	Maintain communication and support for carers and family members if applicable	Encourage carer/family involvement with management if patient willing Refer to carer's advocacy/support groups as appropriate Referral to agencies providing assistance in the home as required/AACAT referral	Cares for brother at home

Team Care Arrangements

Provider Name	Treatment/Service	Goals	No. of visits
Lesley Likens	**Osteopathy**	**Manage chest and upper back discomfort**	

Copy of GP Management Plan offered to patient? Yes - emailed

Copy / relevant parts of the GP Management Plan supplied to other providers? Yes

GP Management Plan added to the patient's records? Yes

Consent to upload health summary to My Health record? No

Date service was completed: 15/04/2025 **Proposed Review Date:** 15/04/2025

I have explained the steps and any costs involved, and the patient has agreed to proceed with the plan. Yes

GP's Signature: x_____ Lauren Hope _____

Date: <Date>

GP Name: <DrName>