COLLABORATIVE MANAGEMENT PLAN	Consumer Details	Medicare No:
Please ( ) if attached	Surname:	Given Name:
☐ Further information/ Reports	Male/Female DOB:	ATSI:
☐ Medication	Address:	Ph:
	Support/Carer Details:	Ph:

Service Provider

Name:	Contact:

Previous Plan: Yes / No

Presentation/Early Warning Signs:

☐ Aggression ☐ Hopelessness ☐ Distress
☐ Anxiety ☐ Irritability ☐ Change in sleep/appetite
☐ Depression ☐ Isolation

Other…………………………………….

Diagnosis: ……..
History: ……
……………. ………

Precipitating Factors:

☐ Abuse ☐ Finance ☐ Relationships
☐ Drugs/Alcohol ☐ Housing ☐ Legal
☐ Employment ☐ Isolation ☐ Sexuality
☐ Spiritual

Other…………………………….

Support: Does person live alone: Yes/No
Other support networks:

☐ Family member ☐ Friend ☐ Work
☐ Community group ☐ Clubs ☐ Other……………………………………..

ISSUES

What purpose would suicide/self harm have for the consumer?……………………………………………………
……

What has prevented consumer harming self previously?……………………………………………………............
……

What else could address the problem? …………………………………………………………………………………
……

CONSUMER GOALS
Plan to address issues (GP Management Plan, Item 721): …………………………………………………………………
……..

CRISIS PLAN (Action to be taken if level of risk escalates):
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Other Service Providers (Team Care Arrangement, Item 723):

Service	Contact Details
1.	
2.	
3.	

Date of Review: ……………………………………………………………………………………………….............
Follow-up:……………………………………………………………………………………………………............

I consent to the appropriate release of information to assist in the coordination of this collaborative plan

Signature (Consumer):……………………………………………………. Date:…………………………………………

Copy of Management Plan provided to: *(please tick}*

Consumer GP Service Provider Family/Carer Other