Government of **Western Australia**
WA Country Health Service

Choice Summary

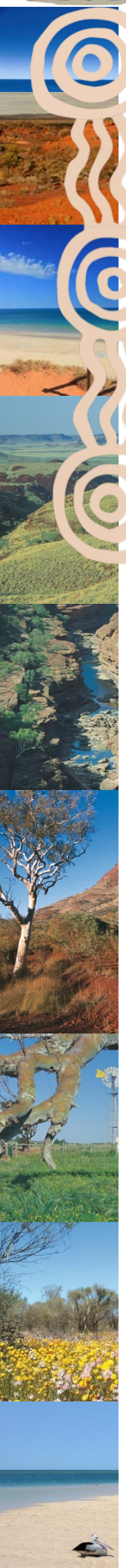
Surname:	UMRN:	
Given Names:	DOB:	Sex:
Address		Postcode:

Date:	Time:	Location:

Attendees: Client, Family Members, Carer, Clinician/s, Others

Why have we come to MMH&CADS: Expectation and Goals? (Views from the Client & Family / other)

Summary of our discussion together:



My Action Plan

Goals	Actions	Who? When?

Further appointment with MMH&CADS (details)

Other/Additional services recommended (e.g. headspace) and details:

Client / Family / Carer declined MMH&CADS (Reason)

Consent obtained for sharing this action plan?
(Please complete boxes below to indicate and identify other)

Yes ☐ No ☐

General Practitioner: (Details)

Referrer: (Details)

Other (Please specify)

Please sign here if you have been involved and agree with this plan

Client: _____ Date:_____ Parent/Carer: _____ Date:_____

Clinician: _____ Date:_____ Other: _____ Date:_____

In the event of an emergency, contact 000 or go to your Local Hospital