Better Access Treatment Plan & Referral Cheat Sheet

Reviewed by the BastionGPT Clinical Advisory Board · July 2026

The GP Mental Health Treatment Plan assesses and manages a diagnosed mental disorder under Australia's Better Access initiative; the separate signed, dated referral is what authorises Medicare-rebated psychology sessions. Two documents, two jobs: conflating them is the costliest habit in this pathway.

Patient agreement & the offered copy claim conditions, not courtesies
Do: record the patient's agreement to proceed, offer a copy of the plan before claiming, and file a copy in the record.
Pitfall: billing the preparation item first; the signature block is template convention, the recorded agreement is not.

Assessment with an outcome tool required unless clinically inappropriate
Do: administer a tool of your choice (K10 and DASS 21 are the named examples), record the score, and re-administer the same tool at review.
Pitfall: skipping the tool silently; if it is clinically inappropriate, the note has to say why.

Formulation & diagnosis provisional counts
Do: a formulation of the disorder with a provisional or formal diagnosis and the history behind it.
Pitfall: a symptom list with nothing formulated or diagnosed; the item requires one.

Goals, treatment & patient actions this patient's, not the template's
Do: agree goals with the patient, record their actions and the education provided, all in writing in the plan.
Pitfall: identical goal text across charts; non-individualised plans are the recurring audit-finding theme.

Crisis & relapse planning complete it or explain it
Do: a plan for crisis intervention and/or relapse prevention, plus referrals, supports, review, and follow-up arranged.
Pitfall: the heading left blank or N/A while the rest of the template is complete.

The referral, a separate document the plan is not a referral
Do: signed and dated, with patient details, symptoms or diagnosis, current medications, the number of services, and the plan statement.
Pitfall: sending the plan alone; the psychologist cannot process rebates against it.

The report back the treating clinician's duty
Do: at the end of the initial course, write to the referrer: assessments carried out, treatment provided, recommendations.
Pitfall: no written report on file when the GP weighs a subsequent course.

Before you sign

- [ ] Agreement recorded, copy offered first
- [ ] Outcome tool named with its score
- [ ] Diagnosis or formulation on the page
- [ ] Goals individualised to this patient
- [ ] Crisis and relapse section completed
- [ ] Referral carries all five elements
- [ ] Session count within course and cap

Drafting with AI

Capture the consult as bullets: the presentation, the tool and score, the goals you agreed, and the sessions you intend to refer.

"Draft a GP mental health treatment plan and a separate Better Access referral from these consult notes, K10 of 27, six focussed psychological strategies sessions: …"

Never paste patient-identifying information into consumer AI tools. BastionGPT is HIPAA-compliant with a signed BAA on every note.

600 to 1,200 words	**25 to 45 min by hand**	**10 + 10 per year**	**GP · psychologist · auditor**
plan plus referral	clinical team estimate	initial course max 6	who reads it

Full guide and sample plan:
bastiongpt.com/template/better-access-treatment-plan

Better Access Treatment Plan & Referral Template

Copy or print for your practice · Adapt fields to your organization's, payer's and jurisdiction's documentation requirements.

Patient (initials): DOB: Plan date:

Referrer (GP or PMP): MyMedicare / usual practitioner:

Agreement and copy
Agreement to proceed recorded; copy offered to the patient before claiming; copy filed

Outcome tool and score
Tool and score, or why clinically inappropriate; same tool re-administered at review

Formulation and diagnosis
Provisional or formal diagnosis with the supporting history

Goals agreed with the patient
Individualised goals in the patient's own priorities

Treatment, patient actions, education
Options discussed, actions agreed, education provided

Crisis intervention / relapse prevention
Early warning signs, contacts, supports, review and follow-up arranged

Referral (separate document)
Patient name, DOB, address; symptoms or diagnosis; medications; number of services; plan statement; signed and dated

Referrer signature: Date signed: