

**Patient education given: No**  
**Copy of this plan given to patient: Yes**  
**Eligibility for the Better Outcomes in Mental Health Care initiative Yes**  
**Review date in months : 3**

I Understand this mental health care plan and agree to its implementation

Patients signature ..... 

Doctors signature ..... 

20th November 2017

K10

◎

<b>In the past 4 weeks:</b>	<b>None of the time</b>	<b>A little of the time</b>	<b>Some of the time</b>	<b>Most of the time</b>	<b>All of the time</b>
<b>1. About how often did you feel tired out for no good reason?</b>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
<b>2. About how often did you feel nervous?</b>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
<b>3. About how often did you feel so nervous that nothing will calm you down?</b>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>