<<Miscellaneous:Practice Letterhead>>

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| **GP MANAGEMENT PLAN - MBS ITEM No 721 (ATRIAL FIBRILLATION)**  |

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| **Patient’s Name:** <<Patient Demographics:Full Name>> | **Date of Birth:** <<Patient Demographics:DOB>> |

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| **Contact Details:**  | **Medicare or Private Health Insurance Details:** |
| <<Patient Demographics:Full Address>> | <<Patient Demographics:Medicare Number>><<Patient Demographics:Health Insurance>> |

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| **Details of Patient’s Usual GP:** | **Details of Patient’s Carer (if applicable):** |
| <<Doctor:Name>><<Doctor:Full Address>> |  |

**Date of last Care Plan/GP Management Plan (if done):** [<<Date of last Care Plan/GPMP>>](##CUSTOM#|D|||10|  /  /    )

**Other notes or comments relevant to the patient’s management plan:**

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**PAST MEDICAL HISTORY**

[<<Clinical Details:History List>>](A)

**FAMILY HISTORY**

<<Clinical Details:Family History>>

**MEDICATIONS**

<<Clinical Details:Medication List>>

**ALLERGIES**

**Patient’s Name:** <<Patient Demographics:Full Name>>

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| **GP MANAGEMENT PLAN - MBS ITEM No 721 (Atrial Fibrillation AF)** |

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| **Patient problems / needs / relevant conditions** | **Goals - changes to be achieved (if possible)** | **Required treatments and services including patient actions** | **Arrangements for treatments/services (when, who, and contact details)** |
| **1. General** |  |  |  |
| Patient's understanding of atrial fibrillation | Patient to have a clear understanding of atrial fibrillation, long term health implications and the patient's role in managing the condition | Patient education | GP/Cardiologist /nurse/ e-tools |
| Stroke prevention plan- review of CHA2DS2-VASc score | Patient to have a clear understanding of personal risk of stroke and the patient's role in prevention | Patient education – annual reassessment if not on anticoagulant | GP/Cardiologist / e-tools |
| Strategy of rate control vs rhythm control (aim to maintain sinus rhythm) | Patient to have a clear understanding of long term strategy for AF rhythm treatment / options | Referral and regular review by Cardiologist / Electrophysiologist for rhythm control options | GP / Cardiologist |
| Episodic AF action plan | Develop action plan for patients with intermittent episodes of AF | GP/ Cardiologist and patient agree on written action plan on management of individual episodes of AF including use of antiarrhythmic/ rate-slowing medication and when to seek medical review | GP/ CardiologistPatient |
| **2. Lifestyle** |  |  |  |
| Nutrition | Healthy eating pattern | Patient educationORAs per Lifescripts action plan | GP/nurse to advisePatient to implementDietician |
| Weight | Your target:BMI £ \_\_Waist £ \_\_ cmIdeal:BMI £ 25Men waist £ 94 cmWomen waist £ 80 cm | MonitorReview 6 monthlyORAs per Lifescripts action plan | Patient to monitorGP/nurse to review |
| Physical Activity | Your target:Ideal:At least 30 minutes walking or equivalent 5 or more days per week | Patient exercise routineORAs per Lifescripts action plan | Patient to implementGP/nurse to review |
| Smoking | Complete cessation | Smoking cessation strategyConsider-Quit-MedicationORAs per Lifescripts action plan | Patient to manageGP/nurse to monitor |
| Alcohol | Your target:£ \_\_ standard drinks per dayIdeal:£ 2 standard drinks per day (men)£ 1 standard drinks per day (women) | Reduce alcohol intakePatient educationORAs per Lifescripts action plan | Patient to manageGP to monitor |
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| **3. Biomedical** |  |  |  |
| ECG | Assess rhythm/ rate control / detect conduction changes / monitor effects of antiarrhythmic drugs | Annual ECG- more frequent if antiarrhythmic drugs used/ doses varied or condition changedHome ECG (Kardia Alivecor) – patient to sample own ECGs for symptoms / monitoring of rhythm  | GP / Cardiologist to monitor AAD use Patient (if chooses to use Kardia Alivecor home monitoring) |
| Echocardiogram | Monitor cardiac / valvular function | Annual test if history LV dysfunction, CCF, >moderate valvular disease; 2 to 3 yearly if none of above but >65 years | GP / Cardiologist |
| Cholesterol / Lipids for stroke prevention | Your target:Cholesterol £ \_\_ mmols/LTriglycerides £ \_\_ mmol/LLDL-C £ \_\_ mmol/LHDL-C ³ \_\_ mmol/LIdeal:Cholesterol £ 4.0 mmols/LTriglycerides £ 2.0 mmol/LLDL-C £ 2.5 mmol/LHDL-C ³ 1.0 mmol/L | Annual check | GP |
| Blood pressure | Your target: <Ideal: < 135/85 | Home BP monitor orCheck with GP every 6 months | PatientGP / nurse  |
| Sleep Apnoea Treatment where applicable | CPAP therapy or as recommended by Sleep Physician | Annual check | Sleep Physician / Nurse |
| **4. Medication** |  |  |  |
| Medication review | Correct use of medications, minimise side effects | Patient educationReview medications | GP /Pharmacist to review and provide education |
| Medication management | Use of Anticoagulants | NOACs first line, renal/ age dosing- annual renal function test | GP to monitor |
|  |  Use of antiarrhythmic drugs for rhythm control | Review efficacy and dose – annual ECG or as required by dose changes | Cardiologist to monitor |
|  | Use of Beta-blockers/ Diltiazem / Verapamil | For rate control | GP to monitor |
|  | Use of Digoxin | When prescribed for rate control – annual serum digoxin level and renal function | GP to monitor |
| **5. Psychosocial** |  |  |  |
| Depression | Manage depression  | Assessment.Medication or cognitive behaviour therapy | GP to assess and initiate management |
| Social isolation | Reduce social isolation | Improve social support eg referral to support group | GP to advise and monitor |

**Copy of GP Management Plan offered to patient?** [<<Copy of GPMP offered to patient?>>](##CUSTOM#|B|||1|N)

**Copy / relevant parts of the GP Management Plan supplied to other providers?** [<<Copy of GPMP supplied to other providers?>>](##CUSTOM#|L|||19|Yes|No|Not Required)

**GP Management Plan added to the patient’s records?** [<<GPMP added to patient's records?>>](##CUSTOM#|B|||1|N)

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| **Date service was completed:** [<<Date service completed>>](##CUSTOM#|D|||10|  /  /    ) | **Proposed Review Date:** [<<Proposed review date (recommended 6 months)>>](##CUSTOM#|D|||10|  /  /    ) |

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| **I have explained the steps and any costs involved, and the patient has agreed to proceed with the plan.** [<<Steps and costs explained, patient agreed>>](CUSTOM#|B|||1|N)GP’s Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |