AOD SHARED CARE MODEL TEMPLATE

Comprehensive assessment | *Care planning* | *Risk management* | *Progress monitoring* | *Transfer of care*

PURPOSE

This template supports coordinated shared care between the patient, GP, Drug Health Services, pharmacy and other providers. Complete collaboratively, use respectful person-centred language and update whenever treatment, risk or responsibilities change.

Patient name{{FIELD_001}}	MRN / DOB{{FIELD_002}}	Date / review period{{FIELD_003}}	Lead clinician{{FIELD_004}}
GP / practice{{FIELD_005}}	Drug Health clinician{{FIELD_006}}	Pharmacy / provider{{FIELD_007}}	Consent / sharing limits{{FIELD_008}}
Interpreter / cultural needs{{FIELD_009}}	Patient goal{{FIELD_010}}	Primary substance(s){{FIELD_011}}	Other services{{FIELD_012}}

Shared-care team and communication

Provider / service	Role in care	Contact	Information shared / consent	Preferred communication
{{TEAM_013}}	{{TEAM_014}}	{{TEAM_015}}	{{TEAM_016}}	{{TEAM_017}}
{{TEAM_018}}	{{TEAM_019}}	{{TEAM_020}}	{{TEAM_021}}	{{TEAM_022}}
{{TEAM_023}}	{{TEAM_024}}	{{TEAM_025}}	{{TEAM_026}}	{{TEAM_027}}
{{TEAM_028}}	{{TEAM_029}}	{{TEAM_030}}	{{TEAM_031}}	{{TEAM_032}}
{{TEAM_033}}	{{TEAM_034}}	{{TEAM_035}}	{{TEAM_036}}	{{TEAM_037}}
{{TEAM_038}}	{{TEAM_039}}	{{TEAM_040}}	{{TEAM_041}}	{{TEAM_042}}

Shared-care purpose and agreed scope:

{{TEXT_043}}

{{TEXT_044}}

After-hours, urgent and emergency arrangements:

{{TEXT_045}}

{{TEXT_046}}

1. Comprehensive assessment

CLINICIAN PROMPT
Assessment should be holistic, culturally safe and trauma-informed. Include substance use, physical and mental health, psychosocial circumstances, strengths, goals and current risks.

Assessment domain	Key findings	Needs / risks	Action / referral
Presenting concern and patient goals	{{FIND_047}}	{{RISK_048}}	{{ACTION_049}}
Substance-use history and dependence	{{FIND_050}}	{{RISK_051}}	{{ACTION_052}}
Withdrawal and intoxication	{{FIND_053}}	{{RISK_054}}	{{ACTION_055}}
Overdose and reduced tolerance	{{FIND_056}}	{{RISK_057}}	{{ACTION_058}}
OAT / current AOD medicines	{{FIND_059}}	{{RISK_060}}	{{ACTION_061}}
Physical health and current medicines	{{FIND_062}}	{{RISK_063}}	{{ACTION_064}}
Mental health, cognition and suicide risk	{{FIND_065}}	{{RISK_066}}	{{ACTION_067}}
Injecting, BBV, wounds and sexual health	{{FIND_068}}	{{RISK_069}}	{{ACTION_070}}
Housing, family, children and safeguarding	{{FIND_071}}	{{RISK_072}}	{{ACTION_073}}
Cultural, spiritual and communication needs	{{FIND_074}}	{{RISK_075}}	{{ACTION_076}}
Legal, financial, employment and transport	{{FIND_077}}	{{RISK_078}}	{{ACTION_079}}
Strengths, supports and previous treatment response	{{FIND_080}}	{{RISK_081}}	{{ACTION_082}}

Clinical formulation: main AOD problem, severity, drivers, protective factors and priority risks:

{{TEXT_083}}

{{TEXT_084}}

{{TEXT_085}}

Working diagnoses / differential considerations:

{{TEXT_086}}

{{TEXT_087}}

2. Care and treatment planning

CLINICIAN PROMPT
Create the plan with the patient. Goals should be meaningful, specific and reviewable. Document choices discussed, informed consent, declined options and who is responsible for each action.

Patient goal	Intervention / action	Responsible person/service	Timeframe	Outcome measure	Review date	Status
{{PLAN_088}}	{{PLAN_089}}	{{PLAN_090}}	{{PLAN_091}}	{{PLAN_092}}	{{PLAN_093}}	{{PLAN_094}}
{{PLAN_095}}	{{PLAN_096}}	{{PLAN_097}}	{{PLAN_098}}	{{PLAN_099}}	{{PLAN_100}}	{{PLAN_101}}
{{PLAN_102}}	{{PLAN_103}}	{{PLAN_104}}	{{PLAN_105}}	{{PLAN_106}}	{{PLAN_107}}	{{PLAN_108}}
{{PLAN_109}}	{{PLAN_110}}	{{PLAN_111}}	{{PLAN_112}}	{{PLAN_113}}	{{PLAN_114}}	{{PLAN_115}}
{{PLAN_116}}	{{PLAN_117}}	{{PLAN_118}}	{{PLAN_119}}	{{PLAN_120}}	{{PLAN_121}}	{{PLAN_122}}
{{PLAN_123}}	{{PLAN_124}}	{{PLAN_125}}	{{PLAN_126}}	{{PLAN_127}}	{{PLAN_128}}	{{PLAN_129}}
{{PLAN_130}}	{{PLAN_131}}	{{PLAN_132}}	{{PLAN_133}}	{{PLAN_134}}	{{PLAN_135}}	{{PLAN_136}}
{{PLAN_137}}	{{PLAN_138}}	{{PLAN_139}}	{{PLAN_140}}	{{PLAN_141}}	{{PLAN_142}}	{{PLAN_143}}

Treatment options discussed: ☐ Brief intervention ☐ Counselling ☐ Withdrawal care ☐ OAT ☐ Alcohol relapse-prevention medicine ☐ Rehabilitation ☐ Peer/family support ☐ GP/shared care ☐ Harm reduction

Patient preferences, consent and any declined interventions:

{{TEXT_144}}

{{TEXT_145}}

Medication, prescribing, dispensing and monitoring responsibilities:

{{TEXT_146}}

{{TEXT_147}}

Appointment, adherence and missed-contact plan:

{{TEXT_148}}

{{TEXT_149}}

3. Risk management plan

IMMEDIATE SAFETY

If there is reduced consciousness, breathing concern, overdose, seizure, delirium, severe withdrawal, acute psychosis, imminent self-harm/violence or serious medical instability, activate emergency and local escalation pathways immediately.

Risk	Current level	Indicators / triggers	Prevention / mitigation	Early response	Escalation pathway	Owner
Overdose / respiratory depression	{{RISKPLAN_150}}	{{RISKPLAN_151}}	{{RISKPLAN_152}}	{{RISKPLAN_153}}	{{RISKPLAN_154}}	{{RISKPLAN_155}}
Alcohol / benzodiazepine / GHB withdrawal	{{RISKPLAN_156}}	{{RISKPLAN_157}}	{{RISKPLAN_158}}	{{RISKPLAN_159}}	{{RISKPLAN_160}}	{{RISKPLAN_161}}
Opioid withdrawal / relapse after tolerance loss	{{RISKPLAN_162}}	{{RISKPLAN_163}}	{{RISKPLAN_164}}	{{RISKPLAN_165}}	{{RISKPLAN_166}}	{{RISKPLAN_167}}
Intoxication / sedation / falls	{{RISKPLAN_168}}	{{RISKPLAN_169}}	{{RISKPLAN_170}}	{{RISKPLAN_171}}	{{RISKPLAN_172}}	{{RISKPLAN_173}}
Self-harm / suicide	{{RISKPLAN_174}}	{{RISKPLAN_175}}	{{RISKPLAN_176}}	{{RISKPLAN_177}}	{{RISKPLAN_178}}	{{RISKPLAN_179}}
Psychosis / behavioural disturbance / violence	{{RISKPLAN_180}}	{{RISKPLAN_181}}	{{RISKPLAN_182}}	{{RISKPLAN_183}}	{{RISKPLAN_184}}	{{RISKPLAN_185}}
Medical deterioration / pregnancy	{{RISKPLAN_186}}	{{RISKPLAN_187}}	{{RISKPLAN_188}}	{{RISKPLAN_189}}	{{RISKPLAN_190}}	{{RISKPLAN_191}}
Medication error / missed OAT doses / diversion	{{RISKPLAN_192}}	{{RISKPLAN_193}}	{{RISKPLAN_194}}	{{RISKPLAN_195}}	{{RISKPLAN_196}}	{{RISKPLAN_197}}
Child safety / domestic and family violence	{{RISKPLAN_198}}	{{RISKPLAN_199}}	{{RISKPLAN_200}}	{{RISKPLAN_201}}	{{RISKPLAN_202}}	{{RISKPLAN_203}}
Homelessness / loss to follow-up	{{RISKPLAN_204}}	{{RISKPLAN_205}}	{{RISKPLAN_206}}	{{RISKPLAN_207}}	{{RISKPLAN_208}}	{{RISKPLAN_209}}

Naloxone and harm-reduction plan:

{{TEXT_210}}

{{TEXT_211}}

Emergency contacts, after-hours instructions and patient safety plan:

{{TEXT_212}}

{{TEXT_213}}

4. Monitoring treatment progress and outcomes

CLINICIAN PROMPT

Monitoring should measure progress toward the patient's goals, treatment response, safety, functioning and experience of care. Review more frequently during induction, withdrawal, instability or major change.

Domain / indicator	Baseline	Target	Current result	Trend	Action / adjustment	Next review
Substance use / days used / quantity	{{OUTCOME_214}}	{{OUTCOME_215}}	{{OUTCOME_216}}	{{OUTCOME_217}}	{{OUTCOME_218}}	{{OUTCOME_219}}
Cravings and withdrawal symptoms	{{OUTCOME_220}}	{{OUTCOME_221}}	{{OUTCOME_222}}	{{OUTCOME_223}}	{{OUTCOME_224}}	{{OUTCOME_225}}
Overdose / intoxication events	{{OUTCOME_226}}	{{OUTCOME_227}}	{{OUTCOME_228}}	{{OUTCOME_229}}	{{OUTCOME_230}}	{{OUTCOME_231}}
Medication adherence and side effects	{{OUTCOME_232}}	{{OUTCOME_233}}	{{OUTCOME_234}}	{{OUTCOME_235}}	{{OUTCOME_236}}	{{OUTCOME_237}}
OAT attendance / missed doses	{{OUTCOME_238}}	{{OUTCOME_239}}	{{OUTCOME_240}}	{{OUTCOME_241}}	{{OUTCOME_242}}	{{OUTCOME_243}}
Physical health / observations / pathology	{{OUTCOME_244}}	{{OUTCOME_245}}	{{OUTCOME_246}}	{{OUTCOME_247}}	{{OUTCOME_248}}	{{OUTCOME_249}}
Mental health and wellbeing	{{OUTCOME_250}}	{{OUTCOME_251}}	{{OUTCOME_252}}	{{OUTCOME_253}}	{{OUTCOME_254}}	{{OUTCOME_255}}
Housing, relationships and functioning	{{OUTCOME_256}}	{{OUTCOME_257}}	{{OUTCOME_258}}	{{OUTCOME_259}}	{{OUTCOME_260}}	{{OUTCOME_261}}
Engagement / appointments / referrals	{{OUTCOME_262}}	{{OUTCOME_263}}	{{OUTCOME_264}}	{{OUTCOME_265}}	{{OUTCOME_266}}	{{OUTCOME_267}}
Patient-reported progress and satisfaction	{{OUTCOME_268}}	{{OUTCOME_269}}	{{OUTCOME_270}}	{{OUTCOME_271}}	{{OUTCOME_272}}	{{OUTCOME_273}}

What is working well?

{{TEXT_274}}

{{TEXT_275}}

What needs to change and why?

{{TEXT_276}}

{{TEXT_277}}

Revised goals, actions and responsibilities:

{{TEXT_278}}

{{TEXT_279}}

5. Transfer of care planning

CLINICIAN PROMPT

Plan transfer early. Transfer is complete only when the receiving service has accepted the patient, essential information has been handed over, medication arrangements are confirmed and the patient knows the plan.

Transfer element	Details / evidence	Completed
Reason for transfer and patient agreement	{{TRANSFER_280}}	☐ Yes ☐ No ☐ N/A
Receiving clinician/service and acceptance confirmed	{{TRANSFER_281}}	☐ Yes ☐ No ☐ N/A
Transfer date and first appointment	{{TRANSFER_282}}	☐ Yes ☐ No ☐ N/A
Current diagnoses and clinical formulation	{{TRANSFER_283}}	☐ Yes ☐ No ☐ N/A
Substance use, last use, withdrawal and overdose history	{{TRANSFER_284}}	☐ Yes ☐ No ☐ N/A
Current medicines, allergies and pathology	{{TRANSFER_285}}	☐ Yes ☐ No ☐ N/A
OAT medicine, verified dose, last dose, missed doses and takeaways	{{TRANSFER_286}}	☐ Yes ☐ No ☐ N/A
Prescriber, pharmacy and authority arrangements	{{TRANSFER_287}}	☐ Yes ☐ No ☐ N/A
Current risks, safety plan and escalation pathway	{{TRANSFER_288}}	☐ Yes ☐ No ☐ N/A
Naloxone and harm-reduction education	{{TRANSFER_289}}	☐ Yes ☐ No ☐ N/A
Outstanding investigations, referrals and follow-up	{{TRANSFER_290}}	☐ Yes ☐ No ☐ N/A
Interpreter, cultural, disability and access needs	{{TRANSFER_291}}	☐ Yes ☐ No ☐ N/A
ISBAR handover completed and documented	{{TRANSFER_292}}	☐ Yes ☐ No ☐ N/A
Patient/carer given written plan and contacts	{{TRANSFER_293}}	☐ Yes ☐ No ☐ N/A
Interim care owner until first receiving appointment	{{TRANSFER_294}}	☐ Yes ☐ No ☐ N/A
Re-entry / rapid review pathway if care destabilises	{{TRANSFER_295}}	☐ Yes ☐ No ☐ N/A

Transfer summary / ISBAR recommendation:

{{TEXT_296}}

{{TEXT_297}}

{{TEXT_298}}

Role	Name / signature	Date / time
Patient / client	{{SIGN_299}}	{{DATE_300}}
Lead clinician	{{SIGN_301}}	{{DATE_302}}
Receiving / shared-care clinician	{{SIGN_303}}	{{DATE_304}}

Shared-care review checklist

☐ Patient goals remain current

☐ Consent and information-sharing limits reviewed

☐ Responsibilities are understood by all providers

☐ Current risks and escalation pathways are clear

☐ Medication and OAT arrangements are verified

☐ Outcome measures and review date are documented

☐ Transfer or discharge planning has commenced

☐ Patient has contacts and knows who to call