Please send a report to the referring GP at the conclusion of the initial session

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| **Patient Information:** |
| Patient Name:       | DOB:       |
| Referring GP:       | Number of Sessions attended:       |
| Date of 1st Session:       | Date of last session:       |
| Further sessions recommended: |  | Yes | [ ]  | No | [ ]  | If yes, Group [ ]  Individual [ ]  |
| **Focussed Psychological Strategies provided:** (Please tick) |
| Assessment | [ ]  | Cognitive Analysis | [ ]  | Interpersonal Therapy | [ ]  |
| MotivationalInterviewing | [ ]  | Psycho-Education | [ ]  | Social Skills Training | [ ]  |
| Stress Management | [ ]  | Parent Management | [ ]  | Relaxation Strategies | [ ]  |
| Exposure Techniques | [ ]  | Anger Management | [ ]  | Self Instructional Training | [ ]  |
| Problem Solving | [ ]  | Activity Scheduling | [ ]  | Behaviour Modification | [ ]  |
| Attention Regulation | [ ]  | Communication Training | [ ]  | Narrative Therapy | [ ]  |
| Mindfulness | [ ]  | Other (please specify):       |
| **Session Information:**  |
| Presenting Problems |       |
| Summary of psychological interventions/focused strategies |       |
| Progress/Outcomes(including pre and post DASS21) |       |
| Continuing problems/concerns(including any obstacles to treatment eg. failure of patient to attend session) |        |
| **Recommendations**:  |       |
| To review overall progress with you |  | [ ]  | To continue to implement skills learnt in the sessions | [ ]  |
| To continue to monitor medication needs with you |  | [ ]  | To pursue additional psychological treatment | [ ]  |
| Comments:  |       |
| **Psychological Service Provider details:**  |
| Name: |       |
| Contact Number: |       |
| Fax: |       |
| **The information I have provided on this form is a true and accurate record of services provided to me:** |
| **Signed:** |  | **Date:**  |       |