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

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **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 | | |  | |
| Motivational  Interviewing | | |  | | | | 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:** | |  | | |