**Psychology Intake form**

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| **Inclusion Criteria** | **Exclusion Criteria** |
| * Paediatric Clients, aged 2-18 years of age * Clients experiencing difficulties in areas such as mental health, learning, development and/or behaviour. Some areas a psychologist can help are: * Cognitive assessment * Autism Spectrum Disorder Assessments * Behaviour support plans * Anxiety & Depression * Emotional regulation * Stress management * Parenting skills * Counselling * Kindergarten and school support | * Eating disorders – please refer to specialist psychologist * Family court * Acute mental health e.g. psychosis/suicide   *Please see* (<https://psychology.org.au/find-a-psychologist>) *for specialisations* |

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| **Our psychologists do not work with the presentations in the exclusion criteria above. Please tick the box below to confirm your understanding of the exclusion criteria:** |
| Yes – I have read and understood the exclusion and inclusion criteria |



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| **Please complete as much information as possible and send to** [**info@desilvakc.com**](mailto:alliedhealth@moira.org.au) | | | |
| **Date of Completion:** |  | **Your Name:** |  |

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| **Client’s Details** | | | |
| **Full Name** |  | **Date of Birth** |  |
| **Address (incl. Postcode)** |  | | |
| **Gender Identity** |  | **Cultural Identity** |  |
| **Preferred Language** |  | **Interpreter Required?** |  |
| **Educational Setting** *(School, Childcare, Kinder)* |  | | |
| **Health Conditions** *(Diagnoses, Medications)* |  | | |

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| **Preferred Contact Person Detail** | |
| **Contact Name** |  |
| **Relationship Type** |  |
| **Email Address** |  |
| **Phone Number** |  |

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| **Funding Details** | | | |
| **Funding Type**  *(Please tick one)* | **NDIS Medicare Private** | | |
| **NDIS Number**  *(if applicable)* |  | **How are the NDIS Funds managed?** |  |
| **Plan Manager Name *(if applicable)*** |  |
| **Has the NDIS Plan or a screenshot of goals and allocated funding been attached with referral form?** | |  | |

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| **Provision: Services Sought (Pick one, both or skip if unsure)** | | | |
| **☐** Assessment *(Assessing what is currently occurring for the client regarding the areas of concern)* | | **☐** Intervention (*Implementing strategies with the client to address areas of concern)* | |
| **Type of Assessment**  *(if known)* |  | **Preferred Session Frequency**  *(Please tick one)* | **Monthly**  **Fortnightly**  **Weekly** |
| **Type of Report**  *(if required)* |  | **Other Frequency** |  |
| **Format of**  **sessions** | **Face to face (in clinic)**  **Outreach (home, educational setting)**  **Virtual** | **Format of sessions** | **Face to face (in clinic)**  **Outreach (home, educational setting)**  **Virtual** |
| **Please also include –** | | | |
| **Preferred day/s of the week:** |  | **Preferred time slot/s:** |  |

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| **Reason for Referral/Summary of Concerns?** | | | | |
| ☐ Mental health | ☐ Behaviour | ☐ Autism Spectrum Disorder | ☐ ADHD | ☐ Social skills |
| ☐ Anxiety | ☐ Advocating for self | ☐ Family therapy | ☐ | ☐ |
| Other? *(Please provide as much detail as possible)* | | | | |

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| **Are there any family court orders in place?** | |
| ☐ Yes ☐ No  Child lives with:  ☐ Both parents in one home  ☐ Both parents in 2 separate homes. If so, what is the percentage split?  Other? Please describe: |

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| **Additional Services that may be required:** | |
| ☐ **Occupational Therapy** | OTs support with meaningful engagement in everyday occupations including: play, mealtimes, dressing, and other activities that are important to your child |
| ☐ **Speech Pathology** | Speech pathologists assist in communication, play, social skills, literacy and conversation skills etc. |

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| **Referrer Details** | | | |
| **Referral Source** | ☐ Internal (from DSKC)  ☐ External | **Referral Date** |  |
| **Name** |  | | |
| **Agency/**  **Organisation** |  | | |
| **Email** |  | | |
| **Contact Number** |  | | |

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| **How did you hear about De Silva Kids Clinic?** |
| ☐Word of Mouth ☐Google ☐Social Media ☐Our website ☐GP  ☐Other Allied Health Practitioner ☐Support Co-ordinator  ☐Other: |

**son for Referral/Summary of Concerns:** *(Please provide as much detail as possible)*

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| **FOR OFFICE USE ONLY** | | | |
| **Date Received** |  | **Processed** |  |
| **Contacted** |  | **Service Agreement Sent** |  |