**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** |
| **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 ☐ NoChild 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** |  |