Child Treatment Plan

Item 2715 / 2717 / 2701 / 2700

Please note the following information MUST be provided before the Child Treatment Plan will be accepted: Patient details, GP details, Problem / Diagnosis, Risk, Patient Consent and GP Signature.

Step 1: Patient Assessment

Patient details

Name:					
Address:					
Phone:		Gender:		DOB:	
Referral date:		Medicare no:			
Is the patient an Aboriginal or Torres Strait Islander?				❐ Yes ❐ No	
Parent/Caregiver name(s):		Relationship:			

GP details

Name:		Phone:	
Organisation:		Address:	

Problem / diagnosis

Number 1	*Number 2*	*Number 3*

Risk assessment

Has current suicidal thoughts	❐ Yes (If yes, please contact NHN.)	❐ No
Has a current plan to end their life	❐ Yes (If yes, please contact NHN.)	❐ No
Has attempted suicide in the last 6 months	❐ Yes (If yes, please contact NHN.)	❐ No
Is at risk of harming others (due to violence/ aggression)	❐ Yes (If yes, please contact NHN.)	❐ No
Other comments:		

Involvement with DCP

Is the patient/family currently involved with DCP? ❑ Yes ❑ No

Are they at risk of being involved with DCP? ❑ Yes ❑ No

Please provide any relevant details:

Medications

Allergies

Relevant physical and mental examination

Patient history

Include relevant biological, psychological and social history including any family history of mental disorders and any relevant substance abuse or physical health problems.

Patient demographics

Has the child ever received specialist mental health care? ❑ Yes ❑ No

Language spoken at home: ❑ English ❑ Italian ❑ Greek ❑ Cantonese ❑ Mandarin

❑ Arabic ❑ Vietnamese ❑ Other, please specify:_________________________

How well does the child speak English:	❑ Very well ❑ Well ❑ Not well ❑ Not at all
Who does the child live with?	
Do they have any siblings?	❑ Yes ❑ No *If yes, please specify:*_______________________
Is the accommodation stable?	❑ Stable ❑ Unstable
Any other living arrangements?	

Psychosocial assessment: *(e.g. childhood, developmental history, school, family)*

Mental status examination:	
Appearance and general behaviour ❑ Normal ❑ Other: _________________________	Mood (depressed/labile) ❑ Normal ❑ Other: _________________________
Thinking (content/rate/disturbances) ❑ Normal ❑ Other: _________________________	Affect (flat/blunted) ❑ Normal ❑ Other: _________________________
Perception (hallucinations etc.) ❑ Normal ❑ Other: _________________________	Sleep (initial insomnia/early morning wakening) ❑ Normal ❑ Other: _________________________

Cognition (level of consciousness/delirium/intelligence) ❑ Normal ❑ Other: ________________________	Appetite (disturbed eating patterns) ❑ Normal ❑ Other: ________________________
Attention/Concentration ❑ Normal ❑ Other: ________________________	Motivation/Energy ❑ Normal ❑ Other: ________________________
Memory (short and long term) ❑ Normal ❑ Other: ________________________	Judgement (ability to make rational decisions) ❑ Normal ❑ Other: ________________________
Insight ❑ Normal ❑ Other: ________________________	Anxiety Symptoms (physical and emotional) ❑ Normal ❑ Other: ________________________
Orientation (time/place/person) ❑ Normal ❑ Other: ________________________	Speech (volume/rate/content) ❑ Normal ❑ Other: ________________________

Other Mental Health Professionals involved in patient care:	
Name/Profession:	Contact number:

Step 2: Mental Health Care Plan

Emergency care/relapse prevention:
Patient/family education given:

Initial action plan:		
GOAL	TREATMENT	REFERRALS
Review date: (Add a recall in MD for 1-6 months after the Plan date)		

Copy of Child Treatment Plan given to parent/caregiver:	❑ Yes ❑ No

Consent to release information

I, ______________________________ (carers name - please print clearly) understand that the aim of this referral to Sonder is to assist my child in addressing any issues associated with emotional and behaviour problems. This involves attending an assessment session with a view to a referral to an appropriate clinician for further therapeutic sessions. I agree to be a part of the process with the knowledge that:

Medical history will be shared with the GP and Clinician of the service chosen/and personnel of the chosen service where relevant;

The information collected is private and will be kept confidential unless agreed upon by all parties to be shared;

My GP has explained to me the reasons for seeking counselling/therapeutic input;

No Medico Legal Reports will be provided

I understand that my treatment will be monitored and communicated between my treatment team and reviewed prior to the 6th session of therapy.

All personal information gathered will remain confidential and secure with my treating team and within the clinical management system hosted by the funding bodies the APHN and CSAPHN.

Parent/Caregiver signature : ________________________________ Date: _____________________________

GP signature: ________________________________ Date: ______________________________

Please fax completed referral form to the Central Referral Unit on 1300 580 249.