

Parents/ Guardians

Please complete this form and return to your school together with your child's Mental Health Plan /referral from your referring GP, paediatrician or psychiatrist.

Student Details

Name of Client _____

Medicare Number Ref No

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Date of Birth _____

Current School Attending _____

School Contact Person _____

Parent/ Guardian Names _____

Address _____

City/Suburb _____ Post Code _____

Contact number _____

Family Law Court Orders / Ivo ? _____

Whom does child with? _____

Medicare Details

Referring Doctors Details _____ Address _____

Provider Number _____ City/ Suburb _____

Clinic _____ Post Code _____

Phone _____ Date of Mental Health Care Plan _____

Office Use Only

Professional details Sonia Panek **Provider Number** 4728071B

Child and Family Assessment

Please complete and return with your child's referral. This information will provide me with valuable understanding about your family and child.

Family Composition:

With whom does your child live with? Family Law Court Orders? IVO? DHS Involvement?

Has the referred child experienced any trauma, including witnessed family violence?

What are the relationships like within your family? How does your child get along with other family, friends and peers?

How does your child view school? Academic abilities? Relationships with teachers and other students?

Could you please describe your child's strengths?

Child and Family Assessment (continued)

What does your child like doing? After school activities, sports, art etc

Does your child or anyone in the family have any health issues? What is the mental health history of the referred child and any other family members? Is there a history or current substance use in family?

Reasons for wanting counselling for your child? Where do behavioural difficulties occur? What do you currently do to manage the behaviour? Has the child had prior counselling? Any other services involved with your family?

Goal/s for counselling:

Is your child on medication?

Consent Form

I _____, parent/ guardian of _____ permit Sonia Panek, counsellor, to provide short term psychological focussed counselling to my son/daughter.

I consent to information exchange between my child's school and Sonia Panek during the duration of counselling.

I further consent to the following exchange of information between Sonia Panek and (any other relevant services involved with your child):

Signed:

Parent/ Guardian/ : _____

Date: _____

Sonia Panek: _____

Date: _____

(parent)

I _____ consent to the principal of my child's school signing the required Medicare rebate form following counselling sessions when I am not present to sign myself

Parent/Guardian: _____

Date: _____