Client did not attend / was unable to be contacted

INITIAL SESSION REPORT  PROGRESS SESSION REPORT  FINAL SESSION REPORT

|  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Client Information:** | | | | | | | | | | | |
| Client Surname:       Given name: | | | | | | | | DOB: | | | |
| Referring GP: | | | | | | | | Number of Sessions attended: | | | |
| Date of 1st Session: | | | | | | | | Date of last session: | | | |
| Further sessions recommended: |  | Yes | |  | No |  | | Individual  Family (children’s  mental health) | | | |
| **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 | |  | Family Therapy | | | | |  | Behaviour Modification | |  |
| Attention Regulation | |  | Communication Training | | | | |  | Narrative Therapy | |  |
| Mindfulness | |  | Other (please specify): | | | | | | | | |
| **Session Information:** | | | | | | | | | | | |
| Initial presenting problems | | |  | | | | | | | | |
| Progress/Outcomes overview | | |  | | | | | | | | |
| Outcome Tool and score | | | Tool type: | | | | Score entry: | | | Score exit: | |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Continuing problems/concerns  (including any perceived obstacles to treatment) | |  | | | |
| **Specific recommendations for the GP**: | | The client has been provided with a relapse prevention toolkit and their individual relapse prevention plan has been added. Please review this plan regularly with the client. | | | |
| **Request for GP:**  Please review overall progress  Please encourage client to continue to implement skills learnt in the sessions  Please continue to monitor medication needs  Please pursue additional psychological treatment for this client. | | | | | |
| **Other comments:** | |  | | | |
| **Mental Health Provider details:** | | | | | |
| **Name:** | |  | | | |
| **Phone number:** | |  | | | |
| **Fax:** | |  | | | |
| **Email:** | |  | | | |
| **The information I have provided on this form is a true and accurate record of services provided to the client listed in this report:** | | | | |
| **Signed:** |  | | **Date:** |  | |