Date_______________

Side by Side Psychology

Kate French, Clinical Psychologist

INITIAL CLIENT CONTACT FORM

Name of person requiring appointment	Age or D.O.B
Parents or care givers name (if client a child)	Phone numbers (*home and mobile)*
Email address	Postal address

Reason for referral-

• Autism/Developmental Assessment *(Paediatrician referral?) (Provide Assessment info)*

• Autism Spectrum Disorder (ASD) related intervention or therapy-anxiety etc,

• Child Psychology therapy- eg. anxiety, depression, school related issues

• Interest in a group therapy program or parenting program-

• Adult mental health (only if an ASD as well).

N.B for first appointments where the client is a child, it is preferable the parent can have at least part of the appointment with the child NOT present in the room the whole time, so that a detailed history can be taken. This may mean two adults may need to attend the appointment, one to be in the meeting and the other to supervise. This is to ensue the parent can discuss concerns freely.

Funding Source

Self with Medicare or private health rebates	HCWA/NDIS (Self/Plan)	Other organisation (only by agreement prior)

Outcome (please indicate)

• Client booked in____

• Client placed on the waiting list________________________________

• To discuss with Kate before booking in___________________________

• How did they hear about this service?____________________________

updated December 2019