**Therapy Services – Expression of Interest**

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| **Name of Child:** |  |
| **DOB / Age:** |  |
| **Referred by:** |  |
| **Main concerns/goals:** |  |
| **Any current concerns regarding risk of harm to self or others?** **Please provide details:** *PLEASE NOTE THAT THIS IS NOT AN EMERGENCY SERVICE – PLEASE PRESENT TO HOSPITAL EMERGENCY DEPARTMENT IF ANY IMMEDIATE CONCERNS FOR SAFETY*  |  |
| **Are there any Family Court or Children’s Court orders that affect this child?** |  |
| **Preferred session frequency** *(will be discussed at initial consultation & regularly reassessed)* | Monthly / Fortnightly / Weekly |
| **Preferred days/times for sessions** *(preferences will be catered for to best of ability based on availability).*  |  |
| **Funding** | Private / Medicare (Mental Health Care Plan) / NDIS |
| **Name of parent/legal guardian for contact** |  |
| **Contact details (Email & Mobile):** |  |
| **Date:** |  |

**IMPORTANT**

**If you have any significant concerns regarding your child or someone else’s wellbeing or are experiencing an emergency, please contact your GP or nearest emergency department.**

Supports may be accessed via Kids Helpline P: 188 551 800 or Lifeline P: 131 114. For urgent mental health telephone support (for children and their parents), please call 1800 048 636.

This EOI does not guarantee services. Suitability for service will be considered on a case-by-case basis to ensure that you and your child receive most appropriate services. Recommendations for alternative service options will be offered where possible, if we are unable to offer services for any reason.

**Please ensure you have read and agree to the Therapy Services Information and Consent document.**

Please note, your psychologist **will not provide any court reports or any medico-legal reports under any circumstances**.