Grand Pacific Health

Child Treatment Plan

Child's details		
Name:		Date of birth:
Aboriginal and/or Torres Strait Islander: Yes No Not sure		Sex: Male Female
Address:		Postcode:
Patient / Carer details		
Name:		Mobile:
Home/work phone:	Preferred contact method:	

Emergency care plan (other family / friends to contact in emergency)

Name	Relationship	Home/work phone	Mobile

Risk Assessment

If there is immediate significant risk, please contact the Mental Health Helpline on 1800 011 511

Risk of non-suicidal self-harm, risk of harm to others:

Identified Risk Factors

Contextual risk factors (single parent families and family separation, children in out-of-home care, harsh or inconsistent parenting)

Social and emotional indicators (attention difficulties, delayed developmental milestones)

Grand Pacific Health

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General assessment

Presenting problems Provide a brief description of the child's difficulties and reason/s for referral (e.g. psychological/emotional/ behavioural / physical problems, learning difficulties, developmental issues, social or peer issues, family difficulties/attachment, and/or other)

Medical and developmental history

Family medical history

Medications

Allergies

Psychosocial functioning

Home and family (List issues regarding living arrangements, number of siblings, changes of living situation, transcience, parental separation, custody issues, supervision, out-of-home care)

Grand Pacific Health

Child Treatment Plan

School	
Name of school:	Grade:
Learning issues (consider literacy, numeracy, attention/concentration, achievement of potential)	Social / behavioural issues (Consider peer relationships, social skills, bullying, aggression, attendance, conduct problems)
Eating, exercise, sleep (Consider nutrition, eating patterns, weight gain/loss, exercise, fitness, energy, sleep)	
Safety (Consider immunisation, domestic violence, bullying, abuse, traumatic experiences, risky behaviour, drug/alcohol use, cigarettes, caffiene)	

Grand Pacific Health

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Problems / actions	
Problem	Action

Consent

I,________________________________(GP name) am referring this child for treatment. I have discussed the proposed referral with the child and their family and am satisfied that they understand the reason for the referral.

GP signature:	Date:

I,________________________________(parent/carer name) declare that the GP has explained why my child has been referred to the above service. I agree to information about my child's mental health and wellbeing, medical and social history being shared between my GP and the appropriate staff involved in the management of my child's health care. I understand that this may occur during a case conference.

Client signature:	Date:

If Grand Pacific Health (GPH) is to be the treatment provider, please send this completed Child Treatment Plan to GPH via secure fax:

4226 6489 or GPH Argus (secure messaging): intake.argus@gph.org.au