Patient Information Sheet

Child / Adolescent Details

Surname: ______________________________

First name(s)_____________________________

Date of birth: __________________

School: ____

Other agencies / helping professionals currently involved (e.g. GP, Paediatrician, School Counsellor)

____

Parent / Guardian Details

Name (s): __________________________ _______________________________

Address:____

Telephone (home): ________________ (mobile): ________________ (work): _______________

Email:

Relationship to child / adolescent: ______________________________________

Referring person / agency

Name: __________________________

Address: ____

Telephone: ________________

I am happy for a copy of an assessment letter(s) to be sent to my GP ☐ Yes ☐ No

GP Name: __________________________

Address: ____

Health Insurance
Fund name: _______________________

Information & Consent Form

Welcome Sleep Matters (administered through to Jeffery&Ree Clinical Psychologists). We provide general psychology services for children and adults and a specialised Insomnia management service. We look forward to proving you with top quality care. Please read this information and sign to indicate your agreement.

Confidentiality

In order to provide your child with the highest standard of psychological care, personal & health information that is relevant to their current situation will be recorded. Client files are either paper-based and held in a secure filing cabinet that is only accessible by Jeffery&Ree/Sleep Matters Clinical Psychologists, or, are electronic and stored securely on our practice management system which meets industry e-security requirements.

All personal information gathered during the provision of psychological service will remain confidential and secure except when: it is subpoenaed by a court, failure to disclose the information would put your child or another person at risk, or your prior approval has been obtained to provide information to another professional, agency, or person (e.g., spouse, parent, employer).

Request for access to personal information

You may request to see the information about your child that is kept on file. You may access the material recorded in the file, subject to exceptions in National Privacy Principle 6. Requests by you for access to information will be responded to within 14 days and an appointment will be made if necessary for clarification purposes.

Communication with your GP and/or other referring doctor.

If your child was referred by a medical practitioner, your psychologist will communicate with them regarding your treatment. This will usually be in the form of assessment and progress letters and phone contact as needed. Written permission is required if you would like to have any other health professionals or third parties included in these communications.

Concerns about management of personal information

If you have a query or concern about the management of your child's personal information, please do not hesitate to ask. The National Privacy Principles (www.privacy.gov.au), describe your rights and how your information should be handled. Ultimately if you wish to make a formal complaint about the management of your personal information, you may do so with the Office of the Federal Privacy Commissioner on 1300 363 992.

Fees

The cost of each 50 minute consultation is **$190-$200, payable on the day of consultation**, by *Eftpos, credit card (Visa & Mastercard only), cash, cheque, or money order.* If you have a GP (care plan), psychiatrist, or paediatrician referral, you may be eligible for a Medicare Rebate of **$124.50 (gap = $65.50-$75.50)** per session. You can claim after each session via the Medicare App (https://www.humanservices.gov.au/customer/services/express-plus-mobile-apps). Please check with your doctor. If you have a psychiatry or paediatrician referral letter or GP Mental Health Care Plan, please bring it to your first appointment. If you are not eligible for Medicare and have private health insurance cover for psychology, please contact your private health insurer in order to discuss the level of rebate you are eligible for.

Cancellation Policy

Appointments are precious. If you need to cancel an appointment, if at all possible, please provide **at least 48 hours notice.** A ***cancellation fee of $50 will be applied if you cancel with less than 48 hours notice***. The full fee is charged if you fail to attend an appointment. We'd rather not have to charge for missed appointments if there is an alternative so please do notify us if you need to change or cancel. Cancelation fees cannot be claimed from Medicare or your private health insurer.

Availability

You can make changes to your appointment times Monday-Friday 9am-5pm by phoning the practice reception service on **6107 6828**. If you would like to speak with your psychologist, please leave a message with the practice reception, and your psychologist will endeavour to return your call within 24 hours (other than when they are on annual leave). If the matter is urgent and you have been unable to contact your psychologist, please call your either your psychiatrist, GP, or an emergency help-line such as Crisis Care (9223 1111).

I (please print name) ______________________________________ have read and understood the above information. I agree to these conditions for the psychological service provided by Ree & Jeffery Clinical Psychologists.

Signature: ___________________________________ Date: _____________________

Insomnia Severity Index

1. Please rate the current (last 2 weeks) **severity** of your sleep problems (for all questions rate '0' if your sleep has not been a problem).

	None	mild	moderate	severe	very severe
Difficulty falling asleep	0	1	2	3	4
Difficulty staying asleep	0	1	2	3	4
Problem waking too early	0	1	2	3	4

2. How satisfied/dissatisfied are you with your current sleep pattern?

Very satisfied		moderately satisfied		very dissatisfied
0	1	2	3	4

3. To what extent do you consider problems with sleep **interfere** with your daily functioning (e.g., daytime fatigue, ability to function at work/daily chores, concentration, memory, mood etc?).

Not at all	a little	somewhat	much	very much
0	1	2	3	4

4. How **noticeable** to others do you think your sleeping problem is in terms of impairing the quality of your life?

Not at all	a little	somewhat	much	very much
0	1	2	3	4

5. How **worried/distressed** are you about current sleep problem?

Not at all	a little	somewhat	much	very much
0	1	2	3	4

Thank you for you time.
If you are attending for assistance with sleep, please also complete the **7 day sleep log (see website)**.
Please bring this paperwork, and you referral/care plan (if you have one) with you to your first session.
We look forward to working with you.

Strengths and Difficulties Questionnaire

P or T 11-1

For each item, please mark the box for Not True, Somewhat True or Certainly True. It would help us if you answered all items as best you can even if you are not absolutely certain. Please give your answers on the basis of this young person's behavior over the last six months or this school year.

Young person's name .... Male/Female

Date of birth..

	Not True	Somewhat True	Certainly True
Considerate of other people's feelings	☐	☐	☐
Restless, overactive, cannot stay still for long	☐	☐	☐
Often complains of headaches, stomach-aches or sickness	☐	☐	☐
Shares readily with other youth, for example books, games, food	☐	☐	☐
Often loses temper	☐	☐	☐
Would rather be alone than with other youth	☐	☐	☐
Generally well behaved, usually does what adults request	☐	☐	☐
Many worries or often seems worried	☐	☐	☐
Helpful if someone is hurt, upset or feeling ill	☐	☐	☐
Constantly fidgeting or squirming	☐	☐	☐
Has at least one good friend	☐	☐	☐
Often fights with other youth or bullies them	☐	☐	☐
Often unhappy, depressed or tearful	☐	☐	☐
Generally liked by other youth	☐	☐	☐
Easily distracted, concentration wanders	☐	☐	☐
Nervous in new situations, easily loses confidence	☐	☐	☐
Kind to younger children	☐	☐	☐
Often lies or cheats	☐	☐	☐
Picked on or bullied by other youth	☐	☐	☐
Often offers to help others (parents, teachers, children)	☐	☐	☐
Thinks things out before acting	☐	☐	☐
Steals from home, school or elsewhere	☐	☐	☐
Gets along better with adults than with other youth	☐	☐	☐
Many fears, easily scared	☐	☐	☐
Good attention span, sees work through to the end	☐	☐	☐

Signature .... Date ....

Parent / Teacher / Other (Please specify):

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Overall, do you think that your child has difficulties in one or more of the following areas: emotions, concentration, behavior or being able to get on with other people?

No	Yes- minor difficulties	Yes- definite difficulties	Yes- severe difficulties
☐	☐	☐	☐

If you have answered "Yes", please answer the following questions about these difficulties:

• How long have these difficulties been present?

Less than a month	1-5 months	6-12 months	Over a year
☐	☐	☐	☐

• Do the difficulties upset or distress your child?

Not at all	Only a little	A medium amount	A great deal
☐	☐	☐	☐

• Do the difficulties interfere with your child's everyday life in the following areas?

	Not at all	Only a little	A medium amount	A great deal
HOME LIFE	☐	☐	☐	☐
FRIENDSHIPS	☐	☐	☐	☐
CLASSROOM LEARNING	☐	☐	☐	☐
LEISURE ACTIVITIES	☐	☐	☐	☐

• Do the difficulties put a burden on you or the family as a whole?

Not at all	Only a little	A medium amount	A great deal
☐	☐	☐	☐

Signature .... Date ....

Mother/Father/Other (please specify:)

Thank you very much for your help

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Please now download and complete the 7-day sleep log and bring it with you to your first appointment.