|  |
| --- |
| **CONSENT** |

I,       give my consent for my child’s:

[ ] Assessment and Plan to proceed

[ ] for information about my child’s mental health being shared with between my treating GP and the clinician/counsellor:

[ ] for information about my child’s mental health being shared with other nominated services to ensure collaboration in his/her care as listed below:

|  |  |
| --- | --- |
| **Name** | **Role** |
|       |       |
|       |       |
|       |       |
|       |       |

[ ] to participate in service experience / satisfaction survey and evaluation

[ ] for deidentified information to be collected by the funder – (select which PHN) PHN and Department of Health for statistical and reporting requirements.

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Guardian’s Signature: Date:** /     /

|  |
| --- |
| **ASSESSING CLINICIAN** |
| **Name**  |       |
| **Date:** |      /     /      |

**Clinician Signature:**