www.growwellbeing.com

Community Wellbeing Services
121 North East Road
Collinswood SA 5081
ABN: 21 626 180 096
Ph: (08) 8234 2562
Fax: (08) 8219 0049
info@growwellbeing.com

CONSENT FORM

Have you obtained a Mental Health Care Plan (MHCP) in the previous 12months: YES / NO / UNSURE (If yes, please provide a copy)

Please note if you have completed a MHCP in the past 12 months you are not required to obtain another plan.

Are you funded for NDIS: YES / NO Are you applying for NDIS: YES / NO

(NB: People 16 years and over may sign their own consent form if competent)

GP Clinic:_____

Dr:_____

Ph:_____

Client details

Full Name:_____

DOB:_____

Date____/____/_____ School (if applicable):_____

Age: _____ Address:_____

Phone (home)_____ Phone (work) _____

Mobile N: _____ Email:_____

Medicare Number: _____ **No** _____ **Exp**_____

Please write a brief statement outlining concerns

_____

_____

_____

_____

_____

Will you obtain a Mental Health Plan from your own GP? Yes ◯ No ◯

If yes, please leave a copy of the Mental Health Plan with the school or send to admin@growwellbeing.com (See Grow Wellbeing contact details at the top of the page) and write down name of the Clinic and/or GP.

Would you prefer Grow Wellbeing consulting GP to visit you and your child at the school?

Yes ◯ No ◯

In referring _____for Grow Wellbeing services, I/We

acknowledge that Grow Wellbeing staff will:

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Provide Therapeutic support for the individual, consult with educational personnel and other relevant professionals, regarding the student, concerning possible outcomes of ongoing consultative support, treatment, or assessment;

1. Grow Wellbeing staff may contact persons who are or have been directly concerned with the care or education of the student (such as teachers, therapists and doctors) to seek information about the student's background, abilities and performance that may be relevant to the service being provided.
2. No sharing of confidential information will occur without explicit written expression from the guardian(s) or client of consenting age.

I/we hereby exempt Grow Wellbeing, its officers and employees, from any liability for injury or loss that may result from findings, opinions or recommendations expressed by Grow Wellbeing staff in relation to the student, and from any liability for any physical injury that may occur to the student whilst under the supervision of Grow Wellbeing staff, on the condition that those staff act conscientiously in accordance with the practices and duty of care normal to their professions.

Name (Parent/Guardian/ Self) _____

I confirm that I have read, understand and agree to the above information:

Date: ____/____/____

PLEASE SIGN AND RETURN THIS ORIGINAL.

Please provide contact details if you would like Grow Wellbeing to contact other professionals regarding your child. That is, GP, Paediatrician, Speech Pathologist, Occupational Therapist, other:

_____

_____

Office Use

L	M	H

Office Use Only
School comments