***Background Information:***

|  |  |
| --- | --- |
| **Child / Adolescent Full Name:**  |  |
| **Date of Birth:** |  |
| **School Name:** |  |
| **Grade / Year Level:** |  |
| **Parent Names:**  |  |
| **Parent (Main) Email Address:** |  |

|  |
| --- |
| **Who referred the child / adolescent for the assessment and why:** |
|  |

|  |
| --- |
| **Child / adolescent’s current difficulties:** |
|  |

|  |
| --- |
| **Achievement of developmental milestones (sitting, walking, talking)** |
|  |

|  |
| --- |
| **Medical concerns / issues:** |
|  |

|  |
| --- |
| **Previous Assessments:** |
|  |

|  |
| --- |
| **Interventions / Support by allied health professionals or school:** |
|  |

|  |
| --- |
| **Any other information:** |
|  |

**Please complete the consent form on the next page.**

#  Consent for a psychological service

It is a legal requirement that consent be provided prior to assessment.

# **Gathering and Disclosure of personal information**

As part of providing a psychological assessment service, *Stars Psychology* needs to collect and record relevant personal information about you (parent/legal guardian) and your child such as names, contact information, medical/developmental history and other relevant information.

Personal information gathered as part of Stars Psychology will remain confidential except when:

1. It is subpoenaed by a court or disclosure is otherwise required or authorized by law;
2. Failure to disclose the information would place you, your child or another person at serious risk to life, health or safety; or
3. Your prior approval has been given to provide a written report to another professional or agency.

------------------------------------------------------------------------------------------------

**Is there a Custody Order, Court Order, Out of Home Care, Guardianship or Kinship Arrangement for your child?** **Yes** [ ]  **/ No** [ ] **.** (please tick as appropriate)

*(If yes, a copy of documents must be provided, prior to the assessment, to Stars Psychology to demonstrate that you have signatory rights to provide consent for the assessment).*

I \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_[INSERT PARENT NAME] have read and understood the information in this Consent Form, am aware of the tests used and the types of results that are possible and have discussed any outstanding questions with the practice/psychologist.

 **Yes,** [ ]  **I give consent /** [ ]  **No, I do not give consent** (please tick as appropriate) for the assessment of \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ INSERT CHILD’s FULL NAME].

Insert Parent Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_