Te Tira Ahu Ika A Whiro
VETERANS' AFFAIRS
New Zealand

PO Box 5146 \ Wellington 6140 \ New Zealand
New Zealand 0800 483 8372 \ Australia 1800 483 837
Rest of world +64 4 495 2070 \ **www.veteransaffairs.mil.nz**

Further Counselling Treatment Request Form

VETERAN'S WHĀNAU MEMBER DETAILS:

Name: .....**Client Number**: .....

Case Manager:.....

1. Please give a detailed account of the presenting condition and symptoms (including your clinical opinion on their diagnosis) and any other relevant information.

2. Please describe how their condition this is impacting on their day to day life using both persons self reported limitations AND an outcome measure / questionnaire of your choice (this can be pain related, function related, body site specific or focused on whole life health).

3. Did any of your recent appointments identify any risks that will affect your treatment plan?

Risks identified?

☐**Yes**

☐**No**

If yes, please comment:

Have you called the client's GP regarding this?

☐**Yes**

☐**No**

Would you like a rehabilitation advisor from Veterans' Affairs to contact you regarding this?

☐**Yes**

☐**No**

4. Is their condition improving, maintaining their current level or getting worse? Please state why there has been a change/no change in symptoms?

5. Please give a detailed review of treatment so far including both treatment with you AND what you have asked them to work on outside of the clinic.

6. What has been the effect of your treatment and the strategies used outside of the clinic on baseline symptoms? Please include both subjective AND objective changes since your last treatment request.

7. What is <u>your</u> treatment plan and goals for the sessions you have requested? Please include timeframes to achieve this AND outline your expectations on whether you feel these sessions will resolve the current symptoms / this episode.

8. What are the self reported client goals for themselves by the completion of these sessions?

9. If these further sessions are unsuccessful in meeting your treatment plan and/or achieving the clients goals what do you feel would then be the best course of action?

Dates of most recent appointment:……...

Cost of sessions/treatment ……..

Number of sessions completed: ……. Number of sessions requested:.....

Frequency of sessions……

Provider's name: ……

Provider's signature:…….. Date: .....

Business name:.....

Profession:.....

Professional Body registered with: .....

Professional Body Registration Number: .....

Phone Number:.....Email:.....