



**Allied Health Professional - Feedback Form**

Minimum Data Set (MDS) Report. Please complete all fields and return to ESDGP after 6 sessions are complete, or therapy has ceased.

**Unique Identifier #**

Session no:	Session no:	Session no:	Session no:	Session no:	Session no:
Date of session:	Date of session:	Date of session:	Date of session:	Date of session:	Date of session:
Length of session: <input type="checkbox"/> 0 - 30 mins <input type="checkbox"/> 31 - 45 mins <input type="checkbox"/> 46 - 60 mins <input type="checkbox"/> > 60 mins	Length of session: <input type="checkbox"/> 0 - 30 mins <input type="checkbox"/> 31 - 45 mins <input type="checkbox"/> 46 - 60 mins <input type="checkbox"/> > 60 mins	Length of session: <input type="checkbox"/> 0 - 30 mins <input type="checkbox"/> 31 - 45 mins <input type="checkbox"/> 46 - 60 mins <input type="checkbox"/> > 60 mins	Length of session: <input type="checkbox"/> 0 - 30 mins <input type="checkbox"/> 31 - 45 mins <input type="checkbox"/> 46 - 60 mins <input type="checkbox"/> > 60 mins	Length of session: <input type="checkbox"/> 0 - 30 mins <input type="checkbox"/> 31 - 45 mins <input type="checkbox"/> 46 - 60 mins <input type="checkbox"/> > 60 mins	Length of session: <input type="checkbox"/> 0 - 30 mins <input type="checkbox"/> 31 - 45 mins <input type="checkbox"/> 46 - 60 mins <input type="checkbox"/> > 60 mins
Type(s) of therapy provided: (see below *)	Type(s) of therapy provided: (see below *)	Type(s) of therapy provided: (see below *)	Type(s) of therapy provided: (see below *)	Type(s) of therapy provided: (see below *)	Type(s) of therapy provided: (see below *)
Was a co-payment collected?  <input type="checkbox"/> Yes Amount: <input type="checkbox"/> No	Was a co-payment collected?  <input type="checkbox"/> Yes Amount: <input type="checkbox"/> No	Was a co-payment collected?  <input type="checkbox"/> Yes Amount: <input type="checkbox"/> No	Was a co-payment collected?  <input type="checkbox"/> Yes Amount: <input type="checkbox"/> No	Was a co-payment collected?  <input type="checkbox"/> Yes Amount: <input type="checkbox"/> No	Was a co-payment collected?  <input type="checkbox"/> Yes Amount: <input type="checkbox"/> No

\* Therapy used: **1** = Diagnostic Assessment; **2** = Psycho-education; **3** = Interpersonal Therapy; **4** = Behavioural interventions; **5** = Cognitive interventions; **6** = Relaxation Strategies; **7** = Skills Training; **8** = Other CBT interventions (please specify); **9** = Other (please specify)

Results of patient outcome measures:

	Initial Consultation	Final Consultation
DASS21		
K10		
EDS		

Conclusion:  Patient not contactable  Patient referred elsewhere  Patient refused treatment  Treatment complete  Treatment incomplete but the referral is closed

Other: \_\_\_\_\_

Did you recommend additional sessions? Yes/No

If Yes, why? \_\_\_\_\_

Please sign \_\_\_\_\_

Name \_\_\_\_\_