

CLINICAL OUTCOMES in ROUTINE EVALUATION THERAPY ASSESSMENT FORM v.2

Site ID	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <small>letters numbers</small>	Age	<input type="text"/> <input type="text"/>
Client ID	<input type="text"/> <input type="text"/> <small>letters numbers</small>	Male	<input type="checkbox"/> Female <input type="checkbox"/>
Sub Codes	TH ID number <input type="text"/> <input type="text"/> <input type="text"/> SC2 numbers <input type="text"/> <input type="text"/> <input type="text"/> SC3 numbers <input type="text"/> <input type="text"/> <input type="text"/>	Employment	<input type="checkbox"/> <input type="checkbox"/>
Referrer(s)	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	Ethnic Origin	<input type="checkbox"/> <input type="checkbox"/>

Referral date	<input type="text"/> <input type="text"/> <small>D D</small>	/	<input type="text"/> <input type="text"/> <small>M M</small>	/	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <small>Y Y Y Y</small>	Total number of assessments	<input type="text"/>
First assessment date attended	<input type="text"/> <input type="text"/> <small>D D</small>	/	<input type="text"/> <input type="text"/> <small>M M</small>	/	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <small>Y Y Y Y</small>	Previously seen for therapy in this service?	Yes <input type="checkbox"/> No <input type="checkbox"/>
Last assessment date	<input type="text"/> <input type="text"/> <small>D D</small>	/	<input type="text"/> <input type="text"/> <small>M M</small>	/	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <small>Y Y Y Y</small>	Months since last episode	<input type="text"/> <input type="text"/> <input type="text"/> <small>Episode</small>
						Is this a follow-up/review appointment?	Yes <input type="checkbox"/> No <input type="checkbox"/>

Relationships/support *Please tick as many boxes as appropriate*

Living alone (not including dependents)	<input type="checkbox"/>	Full time carer (of disabled/elderly etc)	<input type="checkbox"/>
Living with partner	<input type="checkbox"/>	Living in shared accommodation (eg lodgings)	<input type="checkbox"/>
Caring for children under 5 years	<input type="checkbox"/>	Living in temporary accommodation (eg hostel)	<input type="checkbox"/>
Caring for children over 5 years	<input type="checkbox"/>	Living in institution/hospital	<input type="checkbox"/>
Living with parents/guardian	<input type="checkbox"/>	Other <input type="checkbox"/>	<input type="text"/>
Living with other relatives/friends	<input type="checkbox"/>		

Current/previous use of services for psychological problems?
Please tick as many boxes as appropriate

		Concurrent	< 12 mths	> 12 mths
Primary	GP or other member of primary care team (eg practice nurse, counsellor).....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Secondary	In primary care setting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	In community setting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	In hospital setting on sessional basis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Day care services (eg day hospital)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Hospital admission < = 10 days	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Hospital admission > = 11 days	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Specialist	Psychotherapy/psychological treatments from specialist team (sessional)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Attendance at day therapeutic programme	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Inpatient treatment	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other	Counsellor in eg voluntary, religious, work, educational setting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Is the client currently prescribed medication to help with their psychological problem(s)? Yes ☐ No ☐

If yes, please indicate type of medication:

Anti-psychotics <input type="checkbox"/> <small>(neuroleptics/major tranquillizers)</small>	Anti-depressants <input type="checkbox"/>	Anxiolytics/Hypnotics <input type="checkbox"/> <small>(minor tranquillizers)</small>	Other <input type="checkbox"/>
--	---	---	--------------------------------

Brief description of reason for referral

Identified Problems/Concerns

Severity	< 6 months	6-12 months	> 12 months	Recurring/continuous
<input type="checkbox"/> Depression	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Anxiety/Stress	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Psychosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Personality Problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Cognitive/Learning	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Eating Disorder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Physical Problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Addictions	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Severity	< 6 months	6-12 months	> 12 months	Recurring contin.
<input type="checkbox"/> Trauma/abuse	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Bereavement/loss	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Self esteem	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Interpersonal/relationship	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Living/Welfare	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Work/Academic	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Other (specify below)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Risk

	None	Mild	Mod	Sev
Suicide	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Self Harm	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Harm to others	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Legal/Forensic	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

ICD-10 CODES

	F/Z	Main code	Sub-code		F/Z	Main Code	Sub-code
1	<input type="checkbox"/>	<input type="text"/>	<input type="text"/>	.	<input type="text"/>	<input type="text"/>	<input type="text"/>
2	<input type="checkbox"/>	<input type="text"/>	<input type="text"/>	.	<input type="text"/>	<input type="text"/>	<input type="text"/>
3	<input type="checkbox"/>	<input type="text"/>	<input type="text"/>	.	<input type="text"/>	<input type="text"/>	<input type="text"/>
4	<input type="checkbox"/>	<input type="text"/>	<input type="text"/>	.	<input type="text"/>	<input type="text"/>	<input type="text"/>

What has the client done to cope with/avoid their problems? Please tick, and then specify actions

Positive actions ☐

Negative actions ☐

Assessment outcome (tick one box only)

Assessment/one session only	<input type="checkbox"/>
Accepted for therapy	<input type="checkbox"/>
Accepted for trial period of therapy	<input type="checkbox"/>
Long consultation	<input type="checkbox"/>
* Referred to other service	<input type="checkbox"/>
* Unsuitable for therapy at this time	<input type="checkbox"/>

*If the client is not entering therapy give brief reason