Lilydale
Boronia
Nunawading
Croydon

To raise the health and well-being of our communities through collaborative care and clinical excellence

Yarra Valley Psychology Guarantees:

Minimal Waiting Times

Flexible Fee Structure

General and Clinical Psychologists

Male and Female Psychologists

Full Time Reception

Open Five Days a Week

Continuity of care beyond the 10 sessions of a Mental Health Care Plans

NDIS Registered Provider

Please fill out all information on both sides of this form and return it to the school via the details over page.

YVP School Program Referral Form

Child's name: _____

Date of Birth: _____

Reason for Referral:

_____

_____

_____

_____

Teacher: _____

Teacher's e mail: _____

Name of Parents:

_____

In signing this document, we accept that a Yarra Valley Student Counsellor may contact me. I accept the conditions attached (consent form) and give permission for my child to be seen by the Yarra Valley Psychologist.

_____ _____ _____

Signed Relationship to child Date

Parent contact details (signatory): _____

Once you have read and signed both pages of this consent form, please keep a copy for your own records.

Postal Address: PO Box 68 Boronia VIC 3155
Phone: 1300 947 477 Fax: 03 8692 2854 Email: info@yvp.com.au Web: www.yvp.com.au

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Consent form

I consent to the treatment of my son/daughter/ward. I agree to the following

1. Treatment will be provided by a student counsellor from Yarra Valley Psychology
2. The sessions will be held at the school premises, within our clinic or via Telehealth. The student counsellor will liaise with teachers, other allied health staff, the principal to discuss the child's behaviour and gather information about the child. As such the sessions themselves with the child/ parent remain confidential.
3. All information gathered during the sessions will remain with the individual student counsellor for medico- legal reasons.
4. Yarra Valley Psychology student counsellors may use the relevant information collected to discuss with educational personnel and other professionals mainly with the view to improving and supporting learning. Our student counsellor will provide care within the standards of the profession.

Name (Parent/Guardian): _____

Signature: _____ Date: ____/____/_____

Name (Parent/Guardian): _____

Signature: _____ Date: ____/____/_____

Please return this permission form to your school via:

Email:
upwey.south.ps@education.vic.gov.au with the subject header
"YVP School Program"

In-person:
Hand-in to the school office in a sealed envelope marked
"YVP School Program"

Note: **Following this form being received by the school, a discussion will be held between the parent/carer and the Principal/ Welfare Leader prior to YVP providing support.**

Private Health Fund Rebates | Work Cover | TAC | Victims of Crime | Mental Health Care Plans

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