dcafs
Dufferin Child & Family Services
children's mental health · child protection services · developmental support services

"THE TALK-IN CLINIC"

SUMMARY REPORT

Date of Report: _____/_____/_____ (YR / MO / DY)

Clinician(s): _____

File# _____

Client's Name(s):

(1)_____ D.O.B.:_____/_____/_____ (YR / MO / DY) Age:_____

(2)_____ D.O.B.:_____/_____/_____ (YR / MO / DY) Age:_____

How were you Referred to the clinic: _____

Family Members:

_____

_____

_____

_____

_____

_____

Present in Session: _____

_____

_____

What The Clients Wanted From Today's Session:

_____

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Important Current Or Past Information:

_____

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Sept/2009

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Issues Addressed in the Meeting:

Next Steps and Recommendations/Suggestions:

☐ Single Session only
☐ Refer to **CRISIS Open**
☐ Internal Agency Referral
☐ Refer to **Program Waitlist** (C&F, ICF, DO, ICF-0-6, SA) **circle one**
☐ Refer to **Program Open Immediately** (C&F, ICF, DO, ICF-0-6, SA) **circle one**
☐ Refer to **External Community Services** recommended

Clinician's Signature(s): _____

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