



**Privacy notice** – Open Arms will collect the client's personal information for the purpose of offering counselling services to the client. The information you provide in this form will allow us to make contact with the client and to discuss their needs. Open Arms may disclose the client's personal information without their consent in certain circumstances for example: we believe there is a serious threat of harm to the client or another person, or we are required to by law.

If you would like more information on how we manage personal information, please visit the DVA website at <https://www.dva.gov.au/privacy-policy>

## Client demographics

**1. Client's name**

Surname

Given name(s)

**2. Client's date of birth**

**3. OA referral number**

## Presenting concerns

**4. Describe the reason the client came to you for intervention**

**5. Describe the presenting problem(s) intensity, frequency and duration and any prior attempts to resolve the issue**

## Client history

**6. Provide client demographics plus any relevant history that contextualises the presenting problems you have listed.**

Examples include:

- Family history
- Relationship history
- Educational background
- Occupational status and history
- Religious or spiritual beliefs
- Military service and history
- Mental/physical health history
- History of substance abuse
- History of risk
- Social and recreational activities
- Basic life functioning
- Present legal concerns or past issues
- Client's strengths and resources
- Any other environmental or psychosocial factors

## Treating health providers and community supports

**7. Does the client have a General Practitioner (GP)?**

No  ► Go to **9**

Yes

**8. GP details**

Name

Practice

Contact number

Has the GP been informed of the client's engagement with Open Arms?

No  ► Why not?

Yes

**9. Treating healthcare professionals**

**10. Other community supports**

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## Current medications

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**11. Is the client prescribed medications?**

No

Yes

▶ Medication information (including who prescribed the medication), date commenced/prescribed and health condition

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## Risk update

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**12. Please provide an update on the client's current risk state (Harm to self, to others and from others)**

**Please note:**

- **A Risk Assessment Management Plan (RAMP) is also required for all participants.**
- **A wellbeing and safety plan should be developed with the client if required.**

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## Outcomes assessments results

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**13. Have Outcome Assessments been completed?**

No

▶ Provide a brief explanation of why they were not completed.

Yes

▶ Enter results and provide any comments or observations of the outcome assessment results.

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## Case formulation

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### 14. Provide details of:

- **Presenting problem(s)**  
(summary)
- **Predisposing factors**  
Factors that may have led to the development of the problem(s)
- **Precipitating factors**  
Triggers for the presenting problems
- **Perpetuating factors**  
Factors that maintain the problem or prevent resolution
- **Prognostic factors**  
Positive or negative factors that may impact effectiveness of your intervention
- **Hypothesis** about what maintains the presenting problem(s) and what will promote and hinder change

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## Goals, strategies and outcomes

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### 15. List goals of client

Include the therapeutic interventions used to meet the goals and the expected outcomes in relation to each goal. The goals should be client-centred and focused on the client's goals. It may be beneficial to use specific, measurable, achievable, relevant and timely (SMART).

- **Goals:** These are usually behavioural and measurable goals. For example, reducing anxiety, improve sleep or acquire skills to better manage anxiety symptoms.
- **Strategies:** These are the interventions you will utilise to address the above.
- **Outcomes:** This is what you expect will happen to show the goal has been achieved. Usually there will be one outcome for each goal. For example, reduction in particular psychometrics or a return to specific function.

#### Goal 1

Strategy

Outcome

#### Goal 2

Strategy

Outcome

#### Goal 3

Strategy

Outcome

#### Goal 4

Strategy

Outcome

#### Goal 5

Strategy

Outcome

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## Attendance history

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### 16. Enter session dates and attendance

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## Client exit plan

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### 17. Transition to closure ideally occurs when clients have achieved agreed goals or have goals which are better supported through an alternative service.

Exit planning should be discussed with the client from the beginning of care and should cover the episodic model of care, the anticipated length of the episode of care, planned post exit supports (for example, a general practitioner (GP), another health professional, probation and parole, NDIA support, aged care, or a psychiatrist), that client is aware of re-entry provisions and client agreement with the treatment plan.

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## Recommendations

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### 18. Recommendation *(Select one)*

- Closure  
 Extension of care (further sessions)

### 19. Frequency of sessions *(Select one)*

- Weekly       Fortnightly       Monthly  
 Other - please specify

### 20. Comments

### 21. Care plan prepared by:

Counsellor name

Date