

**CLINICAL  
OUTCOMES in  
ROUTINE  
EVALUATION  
THERAPY  
ASSESSMENT  
FORM v.2**

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

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

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

<input type="checkbox"/> 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"/>
<input type="checkbox"/> Living with other relatives/friends	

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

		Concurrent	< 12 mths	> 12 mths
<b>Primary</b>	GP or other member of primary care team (eg practice nurse, counsellor).....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>Secondary</b>	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"/>
<b>Specialist</b>	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"/>
<b>Other</b>	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"/> (neuroleptics/major tranquillizers)	Anti-depressants <input type="checkbox"/>	Anxiolytics/Hypnotics <input type="checkbox"/> (minor tranquillizers)	Other <input type="checkbox"/>
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**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="checkbox"/>	<input type="text"/>	<input type="text"/>
2	<input type="checkbox"/>	<input type="text"/>	<input type="text"/>	<input type="checkbox"/>	<input type="text"/>	<input type="text"/>
3	<input type="checkbox"/>	<input type="text"/>	<input type="text"/>	<input type="checkbox"/>	<input type="text"/>	<input type="text"/>
4	<input type="checkbox"/>	<input type="text"/>	<input type="text"/>	<input type="checkbox"/>	<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
- Accepted for therapy
- Accepted for trial period of therapy
- Long consultation
- \* Referred to other service
- \* Unsuitable for therapy at this time

**\*If the client is not entering therapy give brief reason**