Behaviour Support Pre-Interview Form

Thank you for your referral to Real Therapy Solutions. Completion of the following form before our Behaviour Practitioner meets with you will assist us to better focus our time and your funds on gathering clinical information and working directly with you.

We appreciate the time you can take to complete as much of this form as possible.

Please email this form to the practitioner or provide it to them at the initial meeting.

Client Information

Client Name:	
Client D.O.B:	
Form completed by:	
Length known the Client:	

Does the person have a previous Behaviour Support Plan? Yes / No

Please provide information about other services accessed including respite/ school/ day placement/ employment/ medical professionals and other supports.

Please provide contact details if you are happy for the Practitioner to consult with them.

Other services accessed	Type service	Contact details – phone/ email and address if relevant

Diagnosis

Please list any medical and mental health diagnosis and who diagnosed them.

Diagnosis / Syndrome	Source of Diagnosis

Please list current medications and dosage and reason for prescription.

Medication	Dose	Time Given	Reason	Prescribed By	Last Reviewed By

We are required to ensure that any supports we provide are directly related to a goal on the NDIS plan. If you have not provided your NDIS plan, please outline the goal(s) related to Behaviour Support.

REAL THERAPY SOLUTIONS

What does the person like i.e. favourite food/ activities?

What does the person dislike?

What are the persons strengths/ what do others like about them/ what are they good at?

Please provide any recent relevant reports to the Practitioner to assist with their intervention.

Type of report	Is there a recent report (2 years)? Yes	No	Date completed	Provided to Practitioner Yes	No
Speech - Communication	☐	☐		☐	☐
Speech – Mealtime Management	☐	☐		☐	☐
Occupational Therapy	☐	☐		☐	☐
Psychology	☐	☐		☐	☐
Psychiatrist	☐	☐		☐	☐

Any other reports including medical reports.

Type of Report	Date completed	Provided to Practitioner

What does a typical weekday look like for the person?

WEEKDAY SCHEDULE		
TIME OF ACTIVITY	**DESCRIPTION OF ACTIVITY**	**YES / NO FUNCTIONAL (OFFICE USE ONLY)**

What does a typical weekend look like for the person?

WEEKEND SCHEDULE		
TIME OF ACTIVITY	**DESCRIPTION OF ACTIVITY**	**YES / NO FUNCTIONAL (OFFICE USE ONLY)**

Describe the behaviours of concern.

Describe the Behaviour	How often do they occur (daily, weekly etc)	When is the behaviour most likely to occur?	When is the behaviour least likely to occur?
	N/AChoose an item by clicking above		
	N/A Choose an item by clicking above		
	N/A Choose an item by clicking above		
	N/A Choose an item by clicking above		

	N/A Choose an item by clicking above		

Are there currently any Restrictive Practices in place?

Chemical restraint ☐ any medication prescribed without a mental health diagnosis?
If yes, what is it? _____

Environmental restraint ☐ restriction on the person to move about the environment e.g. locked doors/ gates/ locked fridge or prevention of access to items?
If yes, what is it? _____

Mechanical restraint ☐ restraint to prevent or restrict the persons movement such as a seat belt buckle or harness, or bed rails?
If yes, what is it? _____

Physical restraint ☐ any action or physical force to prevent or restrict the person's movements?
If yes, what is it? _____

Seclusion ☐ Is the person ever confined to a physical space or a room?
If yes, what is it? _____

Thank you for your time to complete the form.

Please return to your Practitioner by email or at the first session.