Child and adolescent psychiatry psychotherapy form

To be submitted by trainees/Fellows completing a Certificate of Advanced Training in Child and Adolescent Psychiatry.

This form may be attached to the end-of-rotation In-Training Assessment (ITA) form or may be submitted when complete directly to the College's training team. **Email:** training@ranzcp.org; **fax:** +61 3 9642 5652; **post:** RANZCP, Training, 309 La Trobe Street, Melbourne VIC 3000, Australia.

Trainees/Fellows must provide psychotherapy to nine discrete patients/dyads/families/groups for at least six sessions after assessment.

Although therapy may continue past the minimum six sessions, where the supervisor is satisfied that the psychotherapy was provided to a proficient standard, the psychotherapy case can be signed off after six sessions but therapeutic contact may continue.

Trainees/Fellows must be supervised by an appropriate supervisor for the particularly modality they undertake. This could include group supervision.

Completion of any three cases will fulfil the Fellowship Stage 3 Psychotherapy requirement.

| Trainee name | | RANZCP ID | |

PATIENT DETAILS

| Case particulars | | Patient age | ○ < 6 yrs
○ 6–12 yrs
○ 13–18 yrs | Modality | ○ structured, manualised
○ dynamically informed
○ dyadic or family/group |

| Indication | |

| Gender | | Date of last session | |

I confirm that I have completed at least six sessions post-assessment with this patient.

| Trainee signature | | Date | |

PATIENT DETAILS

Case particulars		Patient age	< 6 yrs	Modality	structured, manualised
			6–12 yrs		dynamically informed
			13–18 yrs		dyadic or family/group

Indication	

Gender		Date of last session	

I confirm that I have completed at least six sessions post-assessment with this patient.

Trainee signature		Date	

PATIENT DETAILS

Case particulars		Patient age	< 6 yrs	Modality	structured, manualised
			6–12 yrs		dynamically informed
			13–18 yrs		dyadic or family/group

Indication	

Gender		Date of last session	

I confirm that I have completed at least six sessions post-assessment with this patient.

Trainee signature		Date	

SUPERVISOR DECLARATION

I verify that the information completed on this form is an accurate reflection of the trainee/Fellow's cases and therapy sessions.

Supervisor name		RANZCP ID	
Supervisor signature		Date	

DIRECTOR OF ADVANCED TRAINING CONFIRMATION

Director of Advanced Training name		RANZCP ID	
Director of Advanced Training signature		Date	