# Form B: Group Therapy Program Commencement

# Participant Registration

|  |  |
| --- | --- |
| Program Details | |
| Group Program Name |  |
| North Queensland Region |  |
| Approved Clinician Facilitating Group Program |  |
| Number of sessions |  |
| Indicated Group Program Start Date |  |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| No. | Client Initials | Client Redicase Identifier Number – Except if attendee is from an alternative program | Age | Client Contact Phone Number | Current Nominated Approved Clinician (where client is receiving individual sessions)  Indicate here if participant is from another billing source (e.g. Better Access, Private) |
| 1 |  |  |  |  |  |
| 2 |  |  |  |  |  |
| 3 |  |  |  |  |  |
| 4 |  |  |  |  |  |
| 5 |  |  |  |  |  |
| 6 |  |  |  |  |  |
| 7 |  |  |  |  |  |
| 8 |  |  |  |  |  |
| 9 |  |  |  |  |  |
| 10 |  |  |  |  |  |
| 11 |  |  |  |  |  |
| 12 |  |  |  |  |  |

I can confirm as the facilitator of the group that I have reviewed the suitability of the clients noted above and I have determined that they are appropriate to participate in the nominated group therapy program identified on this form

Signed\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Please email completed form to** [joe.petrucci@neaminational.org.au](mailto:joe.petrucci@neaminational.org.au) at least 1 week prior to commence of Group Therapy sessions