MAKE A MELODY
MUSIC THERAPY

Initial Key Contact Meeting

Name of Key Contact:	
Contact Email of Key Contact:	
Counsellor Name:	
Counsellor Email and Phone:	
Details of the service delivery (days, times and room):	
Referral Procedure:	
Acknowledgement that the counsellor has been provided with a copy of the school calendar and all relevant school policies:	
Acknowledgement that the school has been provided with a copy of the HOPE provider's complaints procedures:	
Agreed day and time for weekly Key Contact communication:	
Discussed the requirements for submitting monthly monitoring returns:	

Key Contact Signature: *(Typed is fine)*	
Date:	
Counsellor/Therapist Signature: *(Typed is fine)*	
Date:	

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