



Initial Key Contact Meeting

Name of Key Contact:

Email of Key Contact:

Counsellor/Therapist Name:

Counsellor/Therapist Email

Details of the service delivery (days, times and room):

Referral Procedure:

Plans to Promote the Service: (Reminder of Peer-Led Initiative)

Has the counsellor/therapist has been provided with a copy of the school calendar and all relevant school policies:

Has the school has been provided with a copy of the Make A Melody's complaints procedures:

Agreed day and time for weekly Key Contact communication:

Discussed the requirements for signing Monthly Monitoring Returns:

Key Contact Signature:
(Typed is fine)

Date:

Counsellor/Therapist Signature:
(Typed is fine)

Date: