**ST VINCENT'S MELBOURNE**

**STRENGTHS BRAINSTORMING**

MENTAL HEALTH

STV UR No: ______________

Surname: ______________

Given Name: ______________

D.O.B: ____/____/____

**Please fill in if no PAS label available**

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**Next Steps:** (This may include what you are specifically going to do next time you meet the person and / or what specific steps you may take prior to meeting with the person the next time.)

**Feedback Time:**

| | |
|---|---|
| **Signature:** | **Date:** ___/___/____ |
| **Name:** | **Designation:** |

STRENGTHS BRAINSTORMING – MENTAL HEALTH – ST VINCENT'S MELBOURNE

# ST VINCENT'S MELBOURNE

## STRENGTHS BRAINSTORMING

MENTAL HEALTH

STV UR No: ________________

Surname: ________________

Given Name: ________________

D.O.B: ____/____/____

**Please fill in if no PAS label available**

| **Date of Review (brainstorming):** | ____/____/____ |
|---|---|
| **Date of Strengths Assessment:** (If there are any additional strengths that can be added or expanded upon prior to group supervision, please do so) | ____/____/____ |

**What is the Client's Goal(s)?** (This can reflect what is most important or meaningful to the person at this time and / or future goal that holds some passion for the passion for the person. If you do not know what that is at this time, you can state that here.)

**What would I like help with from the Team?** (This should be a simple statement used to guide the Team in brainstorming. It may be related to helping the person achieving the goal(s), overcoming barriers or challenges related to achieving the goals(s), helping the person to identify a recovery goal, or ideas for engaging the person in a working relationship.)

**Overview of the Current Situation:** (This can be a brief snapshot of where you are at now in relation to helping the person to achieve or identify a goal you have tired so far.)

**Team Brainstorming:**

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STRENGTHS BRAINSTORMING – MENTAL HEALTH – ST VINCENT'S MELBOURNE