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ST VINCENT'S MELBOURNE

	STV UR No:
,	Surname:
	Given Name:
	D.O.B:

	<i> </i>	STRENGTHS BRAINST	ORMING	Given Name:	
,	•	MENTAL HEALT	ГН	D.O.B:/	
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Next Ste may take pr	ps: (This may include rior to meeting with th	e what you are specifically going to deperson the next time.)	do next time you m	eet the person and / or what specific steps you	
Feedbac	k Time:		<u> </u>		
Signatur	·e:		Date:	//	
Name:			Designation	:	



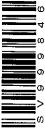
STRENGTHS BRAINSTORMING — MENTAL HEALTH — ST VINCENT'S MELBOURNE



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STV UR No:
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Given Name:
D.O.B:/

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-	STRENGTHS BRA		TORMING	Given Name: D.O.B:/	
	-	MENTAL HEALTH			
Date of	f Review (brainst	orming):			
additional		ssment: (If there are any added or expanded upon prior to			
What is	s the Client's Goa			ingful to the person at this time and / or future	
goal that I	holds some passion for	the passion for the person. If you do	not know what that	t is at this time, you can state that here.)	
What w	vould I like help v	with from the Team? (This sh	nould be a simple st	atement used to guide the Team in brainstorming.	
				lenges related to achieving the goals(s), helping the	
person to	identify a recovery goa	l, or ideas for engaging the person in	a working relations	hip.)	
Ouemie	of the Comment	+ City-stings (
	identify a goal you hav		napshot of where y	ou are at now in relation to helping the person to	
	, , ,	· · · · · · · · ·			
Team B	rainstorming:				
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