Parent & Caregiver Collateral Note Cheat Sheet

Reviewed by the BastionGPT Clinical Advisory Board · August 2026

A parent and caregiver collateral note documents information a clinician gathers from someone other than the client, such as a parent, guardian, or caregiver, and what the clinician did with it. Child and adolescent therapists write one after any substantive caregiver contact. The note lives in the client's chart, attributes every statement to its source, and typically runs 100 to 300 words.

Contact header mode and time, not just who called

Do: record the client identifier and date, the mode of contact (phone, in person, telehealth, written), and start and stop times or total duration.
Pitfall: naming who called but not the mode or time; the note can then neither support nor clearly rule out a billing question later.

Informant and relationship role matters as much as name

Do: name the informant and their relationship or role: mother, stepfather, grandmother with guardianship, group home staff. Guardianship and custody determine who can consent and who may access the record.
Pitfall: assuming the source must always be fully named; a 2024 American Psychiatric Association ethics opinion supports a more general description when a source insists on confidentiality. Decide deliberately, not by habit.

Consent and authorization status which direction information flowed

Do: state the authority for the contact in a line or two: who consented to treatment and caregiver involvement, and whether a release covers anything you disclose.
Pitfall: conflating listening with disclosing. Receiving information from a family member needs no release; sharing the client's information with them does. Write down which way it flowed.

Reason for contact tie it to the treatment plan

Do: say why the contact happened and the plan goal it serves: monitoring skill generalization at home, clarifying a reported incident, gathering developmental history.
Pitfall: a reason that reads as scheduling. New York's guidance defines collateral contact as gathering treatment-relevant information; logistics belong in a care coordination note.

Information reported the flagship discipline: attribute everything

Do: write the informant's account with each statement sourced: mother reports, stepfather states, grandmother describes. One short quote can carry tone.
Pitfall: dropped attribution is the top failure in collateral documentation. Once "struggling at school" appears without a source, the chart asserts it as fact, and every records release repeats it downstream.

Clinician observations and assessment keep appraisal separate from the report

Do: describe what you directly observed during the contact (tone, engagement, use of coached strategies), then your appraisal: consistent with in-session presentation or not.
Pitfall: conclusions drifting up into the reported-information section. Keeping report, observation, and appraisal visibly separate is what makes the note defensible if it reaches a custody dispute.

Disclosure, plan, and signature the regulated direction

Do: record what you shared with the caregiver, kept to the minimum necessary, how the information changes treatment, any follow-up, then a dated, credentialed signature.
Pitfall: documenting what you heard but not what you said. A note silent on disclosure cannot show that the disclosure stayed within consent.

Before you sign

- [ ] Every statement attributed: "mother reports" or equivalent
- [ ] Consent authority named: who agreed, and to what scope
- [ ] Report, observation, and appraisal visibly separate
- [ ] Disclosure to the informant documented, minimum necessary
- [ ] Time, mode, and billing status explicit
- [ ] Written knowing the client or a parent may read it

Drafting with AI

Dictate a 30-second recap after the call or paste a caregiver email: who contacted you and why, what they reported, what you observed, what you disclosed, and the plan.

"Draft a parent collateral contact note from this recap, 15-minute phone check-in with the mother of a 9-year-old on emotion regulation goals, keep each statement attributed: ..."

Never paste client- or family-identifying information into consumer AI tools. BastionGPT is HIPAA-compliant with a signed BAA on every plan.

100 to 300 words	5 to 10 min by hand	Any substantive contact	Care team · payers · auditors
typical length	clinical team estimate	when it's written	who reads it later

Full guide, sample note, and compliance notes:
bastiongpt.com/template/collateral-contact-note

Parent / Caregiver Collateral Contact Note

Copy or print for your practice · Adapt fields to your organization's, payer's and jurisdiction's documentation requirements.

Client (initials): DOB: Date of contact: Clinician:

Mode: ☐ phone ☐ in person ☐ telehealth ☐ written Start/stop or total duration: _____

Informant name: Relationship / role: Guardianship / custody (if any):

Consent and authorization status

The authority for the contact and, separately, for anything you disclose

Who consented to treatment and caregiver involvement: _____

Release on file for disclosures to this informant: ☐ yes ☐ no Scope of permitted disclosure: _____

Reason for contact

Tie to a treatment plan goal; logistics belong in a care coordination note

Information reported by informant

Attribute every statement to its source: "Mother reports…", "Stepfather states…", "Grandmother describes…". One short quote can carry tone; keep your conclusions out of this section.

Clinician observations and assessment

What you directly observed during the contact, then your appraisal (consistent with in-session presentation or not), kept separate from the report

Information disclosed to informant (minimum necessary): _____

Plan / integration with treatment (follow-up, owner, date): _____

Billing status: ☐ not billed (informational contact) ☐ billed as (code and time): _____

Clinician signature / credentials: Date signed:

Supervisor co-signature (if required): Date:

Full guide, sample note, and compliance notes:
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