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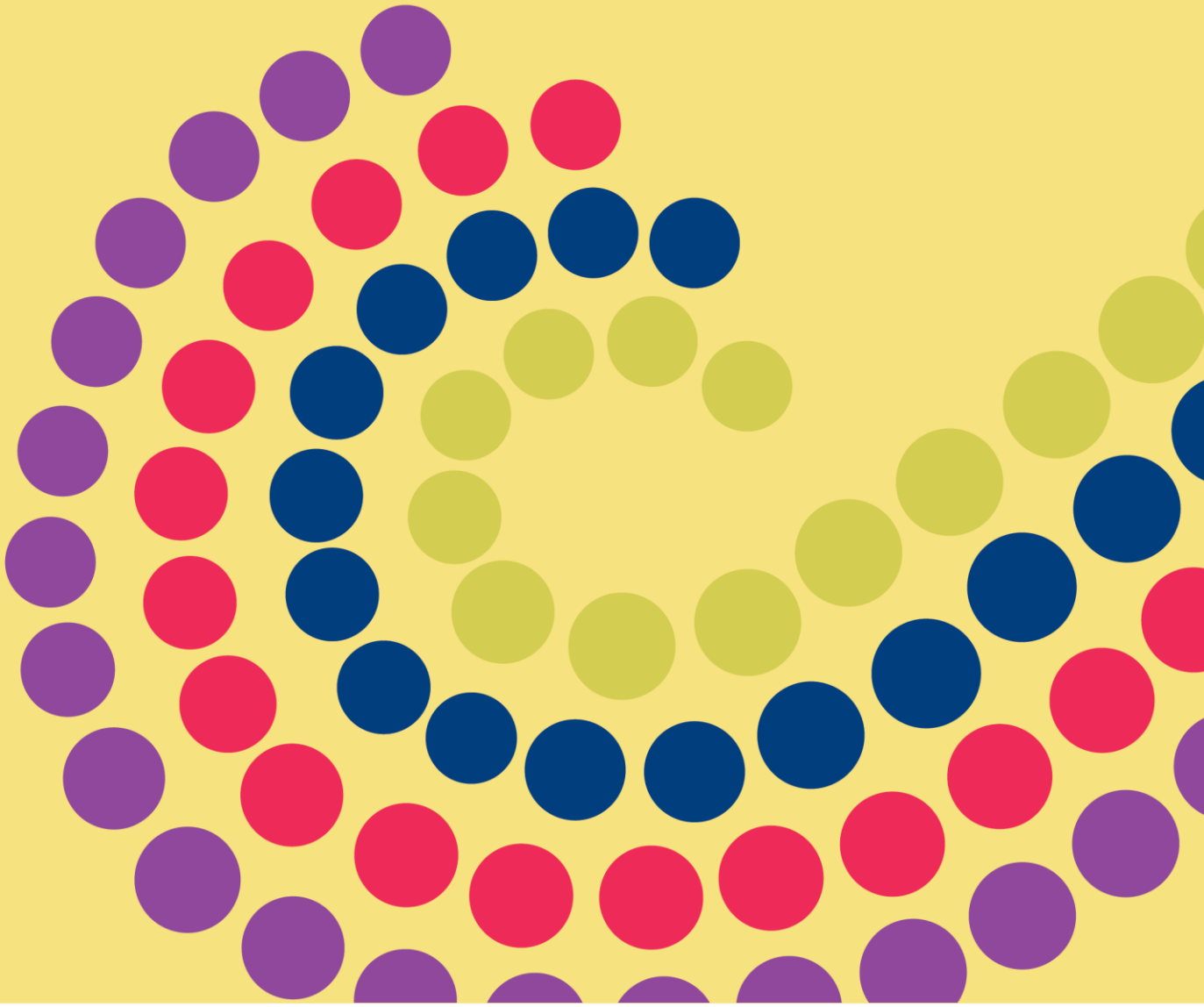
PARENT/GUARDIAN CONSENT FORM

GP ADHD Shared Care Program: A Child & Adolescent Mental Health Services (CAMHS) initiative in partnership with GP Partners Australia (GPPA)

Version 3:
Endorsed Clinical Director CAMHS, Unit Head General Medicine December 2023



Government of South Australia
Women's and Children's Health Network

GP Partners Australia

CREATE together

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The service has been offered to your child as their Paediatrician considers their situation to be stable with optimal medication dosing being achieved. Shared Care with your child's GP will occur in partnership with their Paediatrician and the Adult Psychiatrist who will provide the first Transition Psychiatry Visit, preparing for when your child turns 18 and transitions to adult services.

Return to:
Attention: Leanne March
GP Shared Care Programs Manager
PO Box 579
Unley SA 5061

For more information, scan this QR code to go to:
https://www.gppaustralia.org.au/gp-adhd-shared-care/

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GP ADHD Shared Care Program:

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I, ... (Parent/Guardian name), being the parent/legal guardian of

..... (Patient name), ___/___/_____ (Date of birth) confirm that:

(Please tick and initial each statement)

- ❑ I have read and understood the Patient Information Summary provided above.

- ❑ My child's referring Paediatrician is:

  .....
  .....
  (Paediatrician Name & Contact Details)

- ❑ I consent to the GP Partners Shared Care Manager contacting me to finalise my child's ADHD Shared Care, including the ADHD Shared Care GP's name address and the date of my first appointment.
  My contact details:
  Mobile/Phone number: .....
  Email:.....
  Postal address: .....

- ❑ I will discuss the program with my child's regular GP, who will determine if they can provide my child's ADHD Shared Care and any associated medication prescribing. My child's regular GP is:

  GP Name, Practice & Contact Details:
  .....
  .....

- ❑ If my child's regular GP is not able to provide my child's ADHD Shared Care, I understand the Shared Care Manager will assist me to connect with an alternative ADHD Shared Care GP registered with the program. My child will continue to see their regular GP for all other care

- ❑ I will ensure my child/dependent attends review appointments with their ADHD Shared Care GP for regular clinical monitoring as outlined in the Paediatrician's original transfer of prescribing letter to the GP (e.g. regular BP, pulse, height and weight checks).

- ❑ I am aware my child/dependent cannot have medication prescribed without regular face-to-face follow-up with their ADHD Shared Care GP, at the time intervals advised by my ADHD Shared Care GP or Specialists.

- ❑ I will ensure my child/dependent attends review appointments with their treating Specialist (Psychiatrist or Paediatrician) as advised by their treating Specialist.

- ❑ I am aware continued prescriptions for my child/dependent's medication will not be issued without attending advised Specialist review appointments.
- ❑ I understand failure of my child/dependent to attend review appointments with their Specialist, except in extenuating circumstances, will lead to termination of the shared care agreement with the GP
- ❑ I will ask my child/dependent's Specialist or ADHD Shared Care GP for information at any time I or my child/dependent does not have a clear understanding of the treatment.
- ❑ I will tell my child/dependent's Specialist and Shared Care GP of any other medication's my child/dependent is taking, including over-the counter products, herbal supplements and naturopathic preparations.
- ❑ I will safely store my child/dependent's medications in a child-proof cupboard
- ❑ I have read the patient information leaflet included with my child/dependent's medication and will report any side effects or concerns to my child/dependent's ADHD Shared Care GP and Specialist.
- ❑ I will adhere to the treatment as advised, and will let my Shared Care GP and Specialist know if there are any problems with this.
- ❑ I understand there are no special costs for the GP ADHD Shared Care Program but that my child/dependent's ADHD Shared Care GP's normal out-of-pocket costs will continue to apply.
- ❑ I will seek explicit information regarding any out-of-pocket costs with my child/dependent's Shared Care GP prior to booking an appointment under their care.

Acknowledging the above, I hereby consent to my child/dependent's enrolment in GP ADHD Shared Care Program.

I also consent to the sharing of relevant health information regarding my child/dependent with the following members of their health care team (please leave blank if do not apply):

□ Child & Adolescent Mental Health Service (CAMHS)
□ Paediatrician ……
□ General Practitioner ……
□ Psychiatrist……
□ Private therapists, e.g. ADHD therapist, developmental educator, psychologist, Occupational Therapist
……
□ Other ……

Signature: ..... ****PLEASE SIGN HERE****

Printed Name:……

Date: ……../……../……

Valid until ……../……../…….. unless withdrawn earlier in writing.