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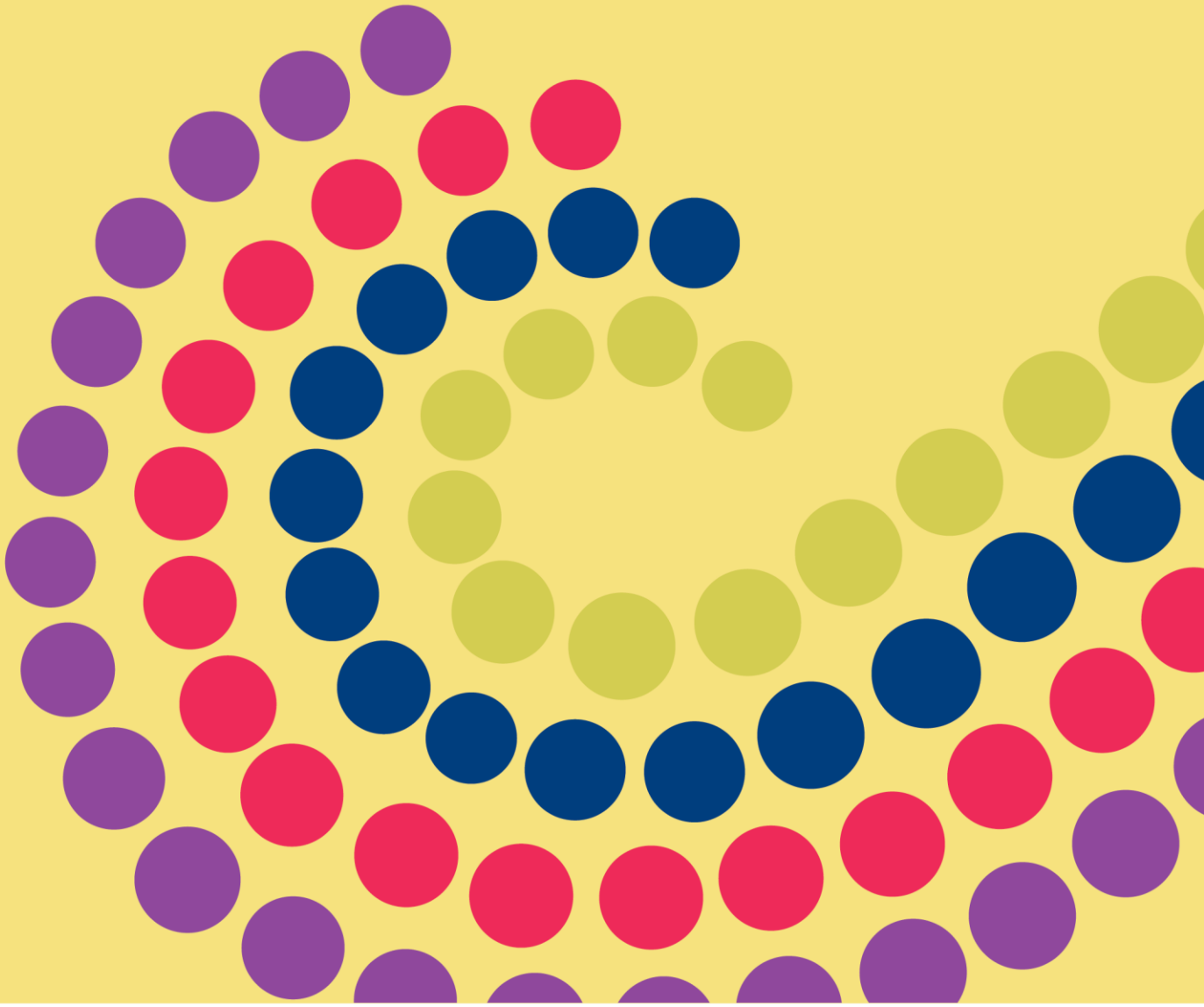
YOUNG PERSON CONSENT FORM

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

GP ADHD SHARED CARE YOUNG PERSON'S CONSENT FORM

The service has been offered to you as your Paediatrician considers your situation to be stable with optimal medication dosing being achieved. Shared Care with your GP will occur in partnership with your Paediatrician and the Adult Psychiatrist who will take on your care, preparing for when you turn 18 and transition to adult services.

Return to:

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

For more information go to:
https://www.gppaustralia.org.au/gp-adhd-shared-care/

Or scan the QR code:

GP Shared Care ADHD

ADHD SHARED CARE

GP ADHD SHARED CARE YOUNG PERSON'S CONSENT FORM

I, ... (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 referring Paediatrician is:

  ……
  ……
  (Paediatrician Name & Contact Details)

- ❑ I consent to the GP Partners Shared Care Manager contacting me to finalise my ADHD Shared Care, including my 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 regular GP, who will determine if they can provide my ADHD Shared Care and any associated medication prescribing. My regular GP is:

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

- ❑ If my regular GP is not able to provide my 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. I will continue to see my regular GP for all other care
- ❑ I will ensure I attend review appointments with my Shared Care GP for regular clinical monitoring as outlined in my Paediatrician's original transfer of prescribing letter to my GP (e.g. regular BP, pulse, height and weight checks).
- ❑ I am aware I cannot have medication prescribed without regular face-to-face follow-up with my Shared Care GP, at the time intervals advised by my Shared Care GP or specialists.
- ❑ I will ensure I attend review appointments with my treating specialist (psychiatrist or paediatrician) as advised by my treating specialist.
- ❑ I am aware continued prescriptions for my medication will not be issued without attending advised specialist review appointments.
- ❑ I understand failure to attend review appointments with my specialist, except in extenuating circumstances, will lead to termination of the shared care agreement with the GP

- ❑ I will ask my specialist or ADHD Shared Care GP for information at any time I do not have a clear understanding of the treatment.
- ❑ I will tell my specialist and Shared Care GP of any other medication's I am taking, including over-the counter products, herbal supplements and naturopathic preparations.
- ❑ I will safely store my medications in a child-proof cupboard
- ❑ I have read the patient information leaflet included with my medication and will report any side effects or concerns to my 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 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 Shared Care GP prior to booking an appointment under their care.

Acknowledging the above, I hereby consent to my enrolment in GP ADHD Shared Care Program.

I also consent to the sharing of relevant health information with the following members of my health care team (please leave blank if they 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.