NORTHERN KENTUCKY PEDIATRIC GROUP

Patient Name_____

Patient DOB_____

Depression and Anxiety Contract

You/your minor child has been diagnosed depression and/or anxiety. Medications for depression and anxiety are only prescribed after reviewing parent and child screening tools and evaluating children and adolescents by interview. At times feelings of depression and anxiety can be caused by illness and your nurse practitioner or physician (health care provider) will conduct a full physical examination as needed. Common side effects of your medication will be reviewed

Your understanding and cooperation with the following guidelines are required for your child to receive treatment of their depression and anxiety.

_____ I understand that psychotherapy has been proven to be the most effective form for Mental Health (MH) care. At times, MH medications may be warranted along with psychotherapy

_____ Prescribed medication for MH issues is not a "cure" for anxiety or depression. Prescribed medication offers a lessening of symptoms to balance mood and to help control the symptom to help with learning and improvement of social function.

_____ At times medication is a first line treatment for MH disorders. It is expected that psychotherapy begins shortly after medication begins.

_____ A Boxed Warning. This type of warning is also commonly referred to as a "black box warning." It appears on a prescription drug's label and is designed to call attention to serious or life-threatening risks. For adolescents and young adults, this includes anti-depression and anti- anxiety medications as there is a concern that these medications may increase suicide in adolescents and young adults. At present is it *suggested that the benefits of antidepressant medications likely outweigh their risks to children and adolescents with major depression and anxiety disorders.*

_____ All recommended appointments for follow-up to assess the effects of counseling, physical response to medication and your child's response to prescribed medication must be monitored. If follow up medication appointments are not kept, you may transfer your child's MH care another MH provider. *

_____ I understand that if my child is not up-to-date with MH recommendations a prescription for one month will allowed. You must schedule an appointment with 30 days of this refill, or you may transfer your child's MH care another MH provider. *

_____ Mental health (MH) screens are due prior to MH visits. Well visits and MH visits may be scheduled together when appropriate. Well child check-ups are required annually.

_____ Herbal supplement such as St. John's Wort often decrease the effectiveness of MH medications and can cause possible responses such as gastrointestinal symptoms, allergic reactions, dizziness/confusion, tiredness/sedation and dry mouth. Herbal remedies can produce adverse reactions, some of which can be serious and even potentially fatal.

_____ Certain migraine headaches are often associated with depression. Administration of depression and anxiety medications can promote chemicals causing a condition known as serotonin syndrome. The most common symptoms of serotonin syndrome include skin flushing, diarrhea, rapid heart rate, elevated blood pressure, confusion and headache.

_____ I will contact emergency services such as EMT services immediately if I am concerned with my or my child's safety or behavior, such as threatening suicide other self-harm, harm to others or behavior which cannot be handled in the home. Important phone numbers are below.

_____ I received a copy of the Behavioral Health Medication Information Sheet

National Suicide Prevention Lifeline: 1-800-273-8255
NorthKey Emergency 24 hour access hotline: 859-331-3292 or toll free: 1-877-331-3292
Psychiatric Intake Response Center (PIRC): 513-63-4124

*As possible, your healthcare provider will attempt to assist you in locating another MH provider

Patient Name (PLEASE PRINT)	Patient Date of Birth

Parent or Guardian **Printed Name**	Parent or Guardian **Signature**	Date
Parent or Guardian **Printed Name**	Parent or Guardian **Signature**	Date
Adolescent Patient **Printed Name**	Adolescent Patient **Signature**	Date