Adolescent Consent and Confidentiality

Welcome to the Center for Pediatric and Adolescent Medicine, and thank you for giving us the opportunity to care for your adolescent.

At the Center for Pediatric and Adolescent Medicine, we value parental involvement. Throughout childhood and adolescence, we plan to continue to encourage open communication and shared decision making between parent and child. Just as is recommended during routine childhood visits, we will continue to discuss parenting strategies to help with navigating the sometimes tumultuous time of adolescence.

While encouraging parental involvement, we must, however, also provide adolescent patients with an opportunity to speak privately with a health care provider. We know that concerns about confidentiality may discourage adolescents from seeking necessary medical care and counseling and may create barriers between patient and physician (1).

We know that the leading causes of adolescent mortality are preventable unintentional injuries, homicide, and suicide. The other major dangers to an adolescent’s health often relate to high-risk behaviors such as tobacco, alcohol, and illicit drug abuse and risky sexual behaviors (2). Thus, we plan to offer preventive counseling to address these concerns.

By the age of 12, our clinic personnel plan to routinely offer your adolescent an opportunity to speak privately with our providers during their visit to the clinic. We will discuss adolescent rights with respect to consent and confidentiality, including the laws regarding these issues in the state of Florida and the limits of confidentiality.

In general, consent from a parent or legal guardian is required in order to provide general medical services to a minor (defined as anyone less than 18 years old). However, there are certain situations in which a minor may be able to consent to his or her own medical care. This is true, for example, in the case of a minor who has the permission of a circuit court judge or in the case of a minor who is married or has been married.

There are a few other unique situations in which a minor may consent to ones’ own confidential health care including evaluation and treatment of sexually transmitted diseases and substance abuse treatment. Additionally, there are certain situations in which a minor who is 13 years of age or older may consent to confidential mental health diagnostic, evaluative, and counseling services in the case of an emotional crisis but not to exceed two visits in any 1-week period before involving a parent or legal guardian.

Additionally, as per Florida statutes, a minor may consent to ones’ own maternal health and contraceptive information and services if the minor is married, pregnant, has the consent of a parent or legal guardian, or if the patient may suffer probable health hazards if such services are not provided in the opinion of the physician.
In general, if an adolescent has the legal right to consent to health care related to a certain issue, then that issue is confidential. However, if there are ever concerns for the immediate safety of the adolescent patient or others, then this information may be shared with the necessary authorities.

Upon reaching the age of 18, the young adult may consent to all types of medical care, and that care will be confidential. Only in the case of imminent concerns for danger to self or others would the necessary authorities be contacted.

At the Center for Pediatric and Adolescent Medicine, we look forward to sharing the joys with you as your child grows throughout adolescence into happy and productive young adults. We are here to support your family through the more trying times of adolescence. We value parental involvement, and we encourage open communication between our adolescent patients and their families. We thank you to trusting us with your adolescent’s medical care.

Sources
American Academy of Family Physicians’ Policy about “Adolescent Health Care, Confidentiality”: http://www.aafp.org/about/policies/all/adolescent-confidentiality.html
http://www.leg.state.fl.us/statutes/
PHQ-9 modified for Adolescents (PHQ-A)

Name: ___________________________ Clinician: ___________________________ Date: __________

Instructions: How often have you been bothered by each of the following symptoms during the past **two weeks**? For each symptom put an “X” in the box beneath the answer that best describes how you have been feeling.

<table>
<thead>
<tr>
<th></th>
<th>(0) Not at all</th>
<th>(1) Several days</th>
<th>(2) More than half the days</th>
<th>(3) Nearly every day</th>
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<tbody>
<tr>
<td>1. Feeling down, depressed, irritable, or hopeless?</td>
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<td>2. Little interest or pleasure in doing things?</td>
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<td>3. Trouble falling asleep, staying asleep, or sleeping too much?</td>
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<td>4. Poor appetite, weight loss, or overeating?</td>
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<td>5. Feeling tired, or having little energy?</td>
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<td>6. Feeling bad about yourself – or feeling that you are a failure, or that you have let yourself or your family down?</td>
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<td>7. Trouble concentrating on things like school work, reading, or watching TV?</td>
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<td>8. Moving or speaking so slowly that other people could have noticed?</td>
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<td>Or the opposite – being so fidgety or restless that you were moving around a lot more than usual?</td>
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<td>9. Thoughts that you would be better off dead, or of hurting yourself in some way?</td>
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</table>

In the **past year** have you felt depressed or sad most days, even if you felt okay sometimes?

- [ ] Yes  
- [ ] No

If you are experiencing any of the problems on this form, how difficult have these problems made it for you to do your work, take care of things at home or get along with other people?

- [ ] Not difficult at all  
- [ ] Somewhat difficult  
- [ ] Very difficult  
- [ ] Extremely difficult

Has there been a time in the **past month** when you have had serious thoughts about ending your life?

- [ ] Yes  
- [ ] No

Have you **EVER**, in your WHOLE LIFE, tried to kill yourself or made a suicide attempt?

- [ ] Yes  
- [ ] No

**If you have had thoughts that you would be better off dead or of hurting yourself in some way, please discuss this with your Health Care Clinician, go to a hospital emergency room or call 911.**

Office use only: ___________________________ Severity score: __________

Modified with permission from the PHQ (Spitzer, Williams & Kroenke, 1999) by J. Johnson (Johnson, 2002)
Intake Form

Child’s Name___________________________________________ DOB ________________     Sex _____

Parents’ Names____________________________________________________________________

Address______________________________________________________________________________
_____________________________________________________________________________________

_____________________________________________________________________________________

Sibling(s) Names_________________________________________________ DOB __________________
Sibling(s) Names_________________________________________________ DOB __________________
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Who lives at home? ____________________________________________________________________

Preferred language? Spoken ________________________ Reading ______________________________

May we email you? (circle one) Yes No
Email Address:    Parent: _____________________________  Patient_____________________________

Past Medical History

Birth problems with pregnancy (circle one) Yes No
# of weeks ________/40__

Type?     □ Vaginal     □ C-Section     If C-section, why? _______________________________

Birth weight ___________  Length ___________  Apgars (1-10) _____  _______

Problems after birth? ____________________________________________________________

Was the baby discharged to home with mother? (circle one) Yes  No
If no, why? ________________________________________________________________

Newborn problems:     □ Jaundice     □ Formula allergy     □ Colic
Development – do you have any concerns about any area of your child’s development? (circle one)

Grass motor – (large muscle) walking, climbing, riding, bike  Y  N
Fine motor – (small muscles) writing, manipulating small objects  Y  N
Speech/language – communication, expression, understanding  Y  N
Social – interacting with others, eye contact  Y  N
Cognitive – (older children) progress in school, understanding concepts  Y  N

Has he/she ever had therapy of any kind? (circle one)  Yes  No
if yes, what kind? ________________________________

Hospitalizations? (circle one)  Yes  No  If so, what age and what for? ________________________________

Surgeries:  Yes  No  If yes, what for?
☐ Adenoids/Tonsils ☐ Ear Tubes ☐ Gastrointestinal surgery
☐ Brain Surgery ☐ Heart surgery ☐ Genitourinary surgery

Other: ________________________________________________________

Patient & Family Medical History
Please check if your child or family members had any of the following medical problems under age 40:
Below list the number of the problem, the family member and relationship to the child:
Mother, father, sibling, Maternal or paternal Grandparent, aunt, uncle, etc.

☐ 1. Academic failure  ☐ 15. Urinary tract disorder  ☐ 29. Inflammatory bowel disease
☐ 2. ADHD  ☐ 16. Depression  ☐ 30. Lipid disorder
☐ 5. Asthma  ☐ 19. Drug/alcohol abuse  ☐ 33. Mental retardation
☐ 8. Bipolar disorder  ☐ 22. Genetic disorder  ☐ 36. Other psychiatric disorder
☐ 9. Eczema  ☐ 23. Stomach or gut disorder  ☐ 37. Schizophrenia
☐ 13. Clotting disorder  ☐ 27. HIV/AIDS

_________________________________________________________
**Medications**

Prescriptions:__________________________________________

Over the counter:_____________________________________

Vitamins:____________________________________________

Supplements/herbal:____________________________________

Hormonal therapy:_____________________________________

**Allergies:**

Medicine:_____________________________________________

Food:_________________________________________________

Pollen/Environment____________________________________

**Social Screening**

*(For parent or guardian—please circle one)*

Do you have someone on whom you can count on to be dependable when you need help?  Yes  No

How often in the last week have you felt depressed:

0  1-2  3-4  5-7 days

In the past year, have you had two weeks or more during which you felt sad, blue or depressed, or lost pleasure in things that you usually cared about or enjoyed?  Yes  No

Have you have two or more years in your life when you felt depressed or sad most days even if you felt OK sometimes?  Yes  No

How strong are your family’s religious beliefs or practices?

A. Very strong  B. Strong  C. Not Strong  D. NA

Do you have a religious affiliation? If so, what is your religion? __________________

How often do you read bedtime stories to your child?

A. Frequently  B. Often  C. Occasionally  D. Rarely  E. Never

What does your family do together for fun?_________________________
How often does your family eat meals together?

A. Frequently  B. Often  C. occasionally  D. rarely  E. never

How often does your child use a seat belt (car seat)?

A. Never  B. Rarely  C. Sometimes  D. Often  E. Always

Does your child ride a bike, scooter or skateboard?  Yes  No
If Yes, how often does he/she use a helmet?

A. Never  B. Rarely  C. Sometimes  D. Often  E. Always

Do you feel that you live in a safe place?  Yes  No

In the past year, have you ever felt threatened in your home?  Yes  No

Does anyone in your household smoke?  Yes  No