Essex Pediatrics

Teen Consult Clinic

Permission Slip

Patient Name: _____ **Date of Birth:** _____

Parent/Guardian Name (if applicable): _____

Program Description:

The Teen Consult Clinic is designed to support overall health and well-being through psychoeducation and problem solving. During these 30-minute sessions, You/your child will meet with a member of our mental health team to discuss the referring concern and develop next steps. You/your child will have a follow-up with their doctor approximately one-month after the consult.

Purpose:

The goal of this program is to promote general wellness, provide guidance on healthy lifestyle choices, and offer support in managing stress and maintaining mental well-being.

Program Activities May Include:

- Education about typical developmental issues, stress management, sleep hygiene, and other wellness topics
- Mindfulness and relaxation techniques
- Behavioral health screening and general wellness discussions
- Ongoing support and resources for well-being

Important Note:

The Teen Consult Clinic is **not psychotherapy**. The program does not involve any form of psychotherapy or mental health treatment and is not intended to replace professional counseling or therapy. If the your/your child's provider feels that psychotherapy is indicated, your provider will discuss this recommendation with you.

Consent and Acknowledgment:

I, the undersigned, authorize Essex Pediatrics and its designated staff to conduct the Teen Consult Clinic for the patient named above. I understand that these activities may involve discussions about wellness, mental health, and stress management.

Essex Pediatrics

I acknowledge that all information provided will remain confidential, in accordance with privacy laws, and will only be shared as necessary for the purpose of the Teen Consult Clinic. Notes from the visit will be kept in the youth's medical record.

I also understand that participation in the Teen Consult Clinic is voluntary, and that I can withdraw my consent at any time.

Signature of Patient/Guardian or Patient if over 18:

Signature: _____

Date: _____

Signature of Physician/Authorized Representative:

Signature: _____

Date: _____

Reason for Referral:

Please describe briefly the reason for the referral: