Mental Health Disorder Treatment Policy

Child's name: _____ DOB: _____/_____/_____

Dear parent,

We evaluated your child using the tools recommended by American Academy of Pediatrics and American Academy of Child psychiatry:

□ Detailed history

□ Vanderbilt form by parent

□ Vanderbilt form by teacher

We have also used:

□ PHQ-9 form for depression

□ SCARED form for Anxiety

Based on our evaluation we determined that your child meets diagnostic criteria for:

□ ADHD □ Depression □ Anxiety □ Intermittent Explosive Disorder □ Conduct disorder □ Disruptive Mood Dysregulation Disorder (DMDD) □ Mood disorder NOS □ Suspected Autistic spectrum disorder □ Combination of few or all of the above disorders.

We are here to help you and your child. Your child may benefit from **counseling, medications or combination of both**. When we recommend medication, we do not force you to accept our recommendation. We write prescriptions only when you consent. Please know, **we are unable to get into any disagreement or conflict among parents and caregivers regarding your child's treatment**. It is your responsibility to work with other parent. If we are dragged into parental conflicts, we won't be able to continue your child's care.

We do not prescribe Ativan, Xanax, Valium or Benzodiazepines. We also do not prescribe Lithium.

If your child's disorder is too severe, and beyond our expertise to manage, we will recommend to have your child seen by a child psychiatrist.

Truly yours,

Shahab Eunus, MD

Consenting Parent's Name: _____

Signature: _____ Date : _____/_____/_____