THE AUTISM TELEMEDICINE COMPANY

INFORMED CONSENT FOR Children's Depression Inventory 2™ (CDI 2) SCREENING:

PATIENT NAME: _____
PARENT'S/GUARDIAN'S NAME: _____
DATE OF BIRTH: _____
DATE CONSENT DISCUSSED: _____

The **Children's Depression Inventory 2™ (CDI 2)** (©MHS Assessments (MHS Inc.) can aid in the early identification of depressive symptoms, the diagnosis of depression and related disorders, as well as, the monitoring of treatment effectiveness in children and adolescents ages 7 to 18.
This instrument, authored by the Maria Kovacs, Ph.D., is a norm-referenced assessment based on a U.S. nationally representative sample.
The CDI 2 will assist you in the diagnostic process. When used in combination with other assessment information, results from the CDI 2 can help guide your diagnostic decisions, treatment planning, ongoing monitoring of response to intervention, and evaluating the effectiveness of a treatment program for a child or adolescent with depression.

Possible Benefits:
The CDI 2 serves as an initial screening test for childhood and adolescent depressive disorders. The result of this screening, upon consultation with your child's physician, psychologist, or other appropriately qualified and licensed provider, and in conjunction with other tests, examinations, and assessments will be part of the diagnostic process.

Possible Risks:
As with any medical screening procedure, there are potential risks and cautions associated with the use of this screening instrument. These risks include, but may not be limited to:

- The results and scores of the CDI 2 instrument depend upon the responses entered by the informant and therefore reflect the accuracy of these responses as well as the informant's understanding of the questions.
- The use of this single instrument along should never be used to make a diagnosis of childhood and adolescent depressive disorders and/or therapeutic decisions. The instrument is a screening test and must be followed up by further consultation and testing with the child's licensed qualified provider(s).
- I understand that there are risks and consequences from telemedicine, including, but not limited to, the possibility, despite reasonable efforts on the part of my provider, that: the transmission of my child's medical information could be disrupted or distorted by technical failures; the transmission of my child's medical information could be interrupted by unauthorized persons; and/or the electronic storage of my child's medical information could be accessed by unauthorized persons.

By signing this form, I understand the following:

- I understand that the laws that protect privacy and the confidentiality of medical information also apply to telemedicine, and that no information obtained in the use of telemedicine which identifies my child, or other minor of I have guardianship, or other minor relative I am authorized to seek healthcare services for, or myself will be disclosed to researchers or other entities without my consent.
- As such, I understand that the information disclosed by me during the course of my diagnosis and/or therapy is generally confidential. However, there are both mandatory and permissive exceptions to confidentiality, including, but not limited to reporting child, elder, and dependent adult abuse; expressed threats of violence towards an ascertainable victim; and where I make my mental or emotional state an issue in a legal proceeding.
- I understand that I have the right to withhold or withdraw my consent to the use of the CDI 2 screen at any time.

Patient Consent To CDI 2 screening:

I have read and understand the information provided above regarding the CDI 2 screen, have discussed it with my provider or such assistants as may be designated, and all of my questions have been answered to my satisfaction.
I hereby give my informed consent for the use of the CDI 2 screen on my child and will follow up with my child's regular physician for further interpretation and management.
I also understand and agree that the use of this screening instrument is not intended to and does not constitute medical advice and does not replace any diagnostic examination, evaluation, and management provided to yourself, your child, or dependent by a licensed physician, psychologist, or other healthcare professional in your jurisdiction (see also terms of service at www.autismtelemed.org).
I also agree that the use of this instrument means that I have consented to its use. It also means that I agree with the terms of service and disclaimer at www.autismtelemed.org.

Signature of Patient (or person authorized to sign for patient):
_____

Date: _____

If authorized signer, relationship to patient:
_____

Witness: _____

Date: I have been offered a copy of this consent form (parent, guardian, or patient's initials) _____