**Informed Consent Form for Counselling for a Youth**

**Name of Client: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ File #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**What to expect from your counsellor:**

* The purpose of meeting with a counsellor is to get help with problems in your life that are bothering you or that are keeping you from being successful in important areas of your life. You may be here because you wanted to talk to a counsellor about these problems. You may be here because your parent/guardian, doctor or teacher has concerns about you. I will ask questions and listen to you. Together we will identify goals that are important to **you** and decide how we can work together to achieve them.
* Sometimes, the issues will include things that you do not want your parents/guardians to know about. For most people, knowing that what they say is kept private helps them to feel more comfortable and have more trust in their counsellor. Privacy, also called confidentiality, is an important and necessary part of good counselling.
* It is important that you feel comfortable talking to me about things that are bothering you. If you do not feel that we have a good fit, or my counselling approach is not helpful, please tell me so that we can talk about other options.
* At WECHC, counselling is voluntary. You decide when to start or stop counselling. If you decide to stop counselling, you can re-start at any time in the future by filling out a new referral form.
* It is my hope that counselling will give you new skills to try or a new way of looking at things. For counselling to be most useful, you will have to work on things discussed outside of our time together.
* We will meet up to 10 times (not including rapid assessment appointment). If you do not show for your appointment or give less than 24 hours notice for a cancellation, the unattended appointment will be counted as 1 out of your 10.
* Regular sessions are 45-50 minutes long.

**Potential risks and side effects of the service:**

* Counselling has both benefits and risks. Risks may include having uncomfortable feelings, such as sadness, guilt, anxiety and anger because counselling often means talking about the unpleasant parts of your life. Counselling has been shown to have benefits for individuals involved.

**Expectations of clients:**

* You have to provide at least 24 hours notice to cancel or reschedule an appointment.
* You file will be closed if you miss two appointments without 24 hours notice, **for any reason**. You can re-refer and return to the waitlist for future counselling.
* All appointments are to be scheduled or rescheduled through reception. It is your responsibility to reschedule any missed appointments. I will not call you to reschedule.
* Your file will be closed if there has been no contact or appointments scheduled within 2 months unless we agreed to this ahead of time.
* You reviewed the copy of the information sheets entitled, “Rights and Expectations” and “Complaint Procedure” and agree to what they say.

**Confidentiality:**

* If I see you outside of a counselling session, you do not have to talk to me. I will not approach you and ask about personal information.
* As a rule, I will keep the information you share with me in our sessions private (confidential), unless I have your written consent to share certain information. There are exceptions to this rule that are important for you to understand before you share personal information with me. In some situations, I am required by law or by the guidelines of Social Work to share information whether or not I have your permission.
* Confidentiality **cannot** be kept when:

\* You tell me you plan to cause serious harm or death to yourself, and I believe you really want to and have a way to carry out this threat in the very near future. I must take steps to inform a parent/guardian of what you have told me and how serious I believe this threat to be. I must make sure that you are protected from hurting yourself.

\* You tell me you plan to cause serious harm or death to someone else that can be identified and I believe you really want to and have a way to carry out this threat in the very near future. In this situation, I must inform a parent/guardian, and I must inform the person you want to hurt.

\* You are doing things that could cause serious harm to you or someone else, even if you do not really want to harm yourself or another person. In these situations, I will need to use my professional judgement to decide whether a parent/guardian should be informed.

\* I suspect that you or another child/youth is being abused (physically, sexually or emotionally) or has been abused in the past. In this situation, I am required by law to report to Children’s Aid.

\* You are involved in a court case and judge requests information about your counselling

**Communicating with parent/guardian:**

* Except for situations such as those mentioned above, I will not tell your parent/guardian specific things you share with me in our private sessions. This includes activities and behaviour that your parent/guardian would not approve of or would be upset by. However, if your risk-taking behaviour becomes more serious, and I believe that you are in serious and immediate danger of being hurt, I will communicate this information to your parent/guardian.
* Even if I agreed to keep information confidential, I may believe that it is important for your parent/guardian to know what is going on in your life. In these situations, I will encourage you to tell your parent/guardian and will help you find the best way to tell them. Also, when meeting with your parents, I may sometimes describe problems in general terms, without using specifics in order to help them know how to be more helpful to you.

**Communicating with other adults:**

WECHC:

* Notes about you are stored electronically in your medical chart and can be viewed by other health care providers involved in your care through WECHC (i.e. Doctor, NP).
* Our team of counsellors provides support to one another and receives support from highly experienced regulated health professionals, who are required by law to maintain your confidentiality. During these consultations, your personal information may be discussed. When this occurs, the same principles of and limits to confidentiality exist.

School:

* I will not share any information with your school unless I have your permission and permission from your parent/guardian. Sometimes I may request to speak with someone at your school to find out how things are going for you. It may be helpful in some situations for me to give suggestions to your teacher or counsellor at school. A very unlikely situation might come up in which I do not have your permission but both your parent/guardian and I believe that it is very important for me to be able to share certain information with someone at your school. In this situation, I will use my professional judgement to decide whether to share any information.

Doctors outside of WECHC:

* Sometimes your doctor and I may need to work together (ex. re: medication). I will get your written permission and permission from your parent/guardian in advance to share information with your doctor. The only time I will share information with your doctor even if I don’t have permission is if you are doing something that puts you at risk for serious and immediate physical/medical harm.

**Youth Consent Form and Parent Agreement to Respect Privacy**

**Youth Client and Parent/guardian:**

Signing below indicates that you reviewed and agree to the policies described above and understand the limits to confidentiality.

**Parent/Guardian:**

Check boxes and sign below indicating your agreement to the following.

* I will refrain from requesting detailed information about individual therapy sessions with my child. I understand that I will be provided with periodic updates about general progress, and/or may be asked to participate in therapy sessions as needed.
* Although I know I have a legal right to request written records since my child is a minor, I agree not to request these records in order to respect the confidentiality of my adolescent.
* I understand that I will be informed about situations that could endanger my child. I know this decision to breach confidentiality is up to the therapist’s professional judgement and may sometimes be made in confidential consultations with her consultant/supervisor.
* If applicable, I provided information about custodial arrangements. I will inform the counsellor/WECHC about any changes to child custody/access.

**All children under 12 years of age require parental/legal guardian consent. Any client unable to make an informed consent shall have the consent signed by their parental/legal guardian or substitute decision maker (SDM).**

**Client Name (print):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**First Name Last Name**

**Client Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_ / \_\_\_\_\_\_ / \_\_\_\_\_\_\_ If Consent Given Verbally, state “verbal” in this space Month Day Year**

**\*\*\*\*Person Giving Consent on behalf of Client – Please Complete this Section\*\*\*\***

**Parent/Guardian/SDM Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**First Name Last Name**

**Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_ / \_\_\_\_\_\_ / \_\_\_\_\_\_\_ If Consent Given Verbally, state “verbal” in this space Month Day Year**

**\*\*\*\*Provider Obtaining Consent– Please Complete this Section\*\*\*\***

**Provider Name (print): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**First Name Last Name**

**Provider Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_ / \_\_\_\_\_\_ /\_\_\_\_\_\_\_ Month Day Year**

**Information About Child Custody and Access**

Child’s Name: Date of Birth:

Type of Custody is (please check):

* Sole
* Joint
* Parents still together

|  |  |
| --- | --- |
| **Name of Parent(s) with Custody** | **Contact Information** |
|  |  |
|  |  |

Custody Arrangement is (please check):

* Final (Involvement of lawyers and Court)
* Interim/temporary (Involvement of lawyers and Court)
* Informal

If applicable:

Name of parent with access (noncustodial):

Name of parent with no access:

* I confirm that the information given in this form is true, complete and accurate.
* I agree to let the therapist know if there are any changes to custody and access regarding my child.
* I confirm that the therapist requested to see/copy legal documentation regarding custody and access.

**All children under 12 years of age require parental/legal guardian consent. Any client unable to make an informed consent shall have the consent signed by their parental/legal guardian or substitute decision maker (SDM).**

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**First Name Last Name**

**Client Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_ / \_\_\_\_\_\_ / \_\_\_\_\_\_\_ If Consent Given Verbally, state “verbal” in this space Month Day Year**

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**Provider Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_ / \_\_\_\_\_\_ /\_\_\_\_\_\_\_ Month Day Year**