Refer to Psychiatrist

(Utilize ACCESS MH-CT if need)

to connect patient to care)

(Appendix F)

1) PCP continues to see patient as "bridge" provider at regular intervals until patient is in active treatment with

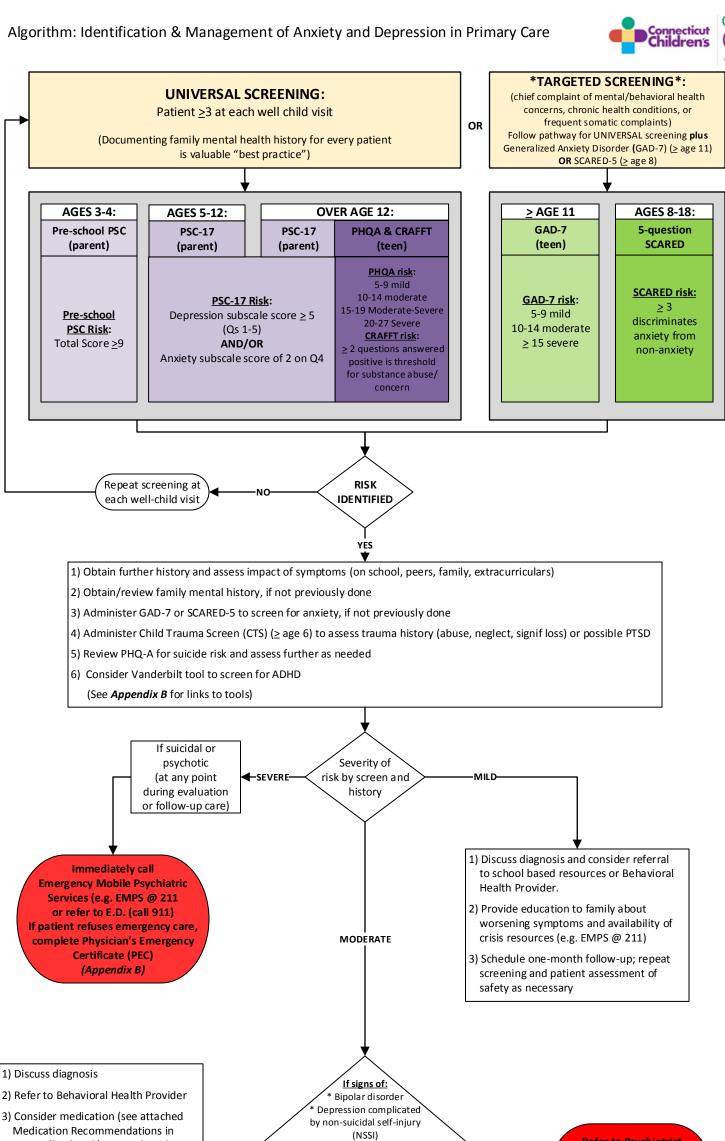
psychiatrist

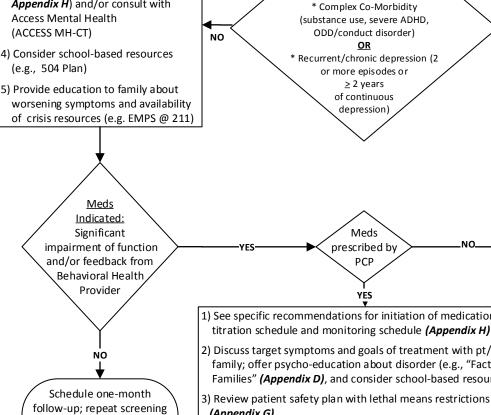
psychiatrist

2) Request ongoing

communication with

YES





- 1) See specific recommendations for initiation of medication titration schedule and monitoring schedule (Appendix H)
- 2) Discuss target symptoms and goals of treatment with pt/ family; offer psycho-education about disorder (e.g., "Facts for Families" (Appendix D), and consider school-based resources
- (Appendix G).
- 4) Review black box warning (Appendix E)
- 5) Request ongoing communication with patients Behavioral Health Provider

PCP Follow-Up Evaluation:

- 1) Follow standard of care
- 2) Re-assess family stressors, and repeat initial anxiety/ depression screening
- 3) Assess treatment outcomes to measure patient progress: reduction in PHQA or screening tool score and/or improvements in daily functioning assessed by clinical interview
- 4) Refer to follow-up frequency indications (Appendix C).
- 1) Continue tx for additional 6-9 months to prevent

and patient assessment of

safety as necessary.

Appendix H) and/or consult with

- 2) Schedule 3-month interval f/up evals. At each visit: - repeat initial depression/anxiety screen
- assess for high-risk behaviors and suicidality 3) At 12 months, if symptoms remit, consider
- tapering medication down gradually by 25% every 2-4 weeks. Monitor for signs of relapse. If relapse, resume medication dose that was successful for additional 6-12 months of treatment (Appendix C).

