



Private outpatient clinic

Centre for mental health

Clinic of Psychiatry and

Psychotherapy

Department of Psychiatry, Psychosomatics
and psychotherapy in childhood and adolescence

Medical director Prof. Dr. med. Renner

Osianderstraße 14

72076 Tübingen

Contact person:

Frau Steinhilber

Tel.: +49 (0)7071/ 29 62461

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direktorat.kjp@med.uni-tuebingen.de

Emergency number

Tel.: +49 (0)7071/ 29 62465

Dear patients,

dear parents,

you contacted us to get an appointment in our ambulance. In order for us to process the appointment smoothly, we ask you to fill in the attached documents and return them to us in full. Afterwards we'll contact you for an appointment.

The following documents need to be completed:

- Application form,
 - declaration of consent
- Medical history sheet

With kind regards,

Dr. H. Spieles
Senior physician

P. Schneider
Therapeutic outpatient management



Application form for private outpatient clinic

Procedure:

Please fill out all the necessary forms.
Afterwards we'll contact you for an appointment.

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Universitätsklinikum Tübingen
Abteilung Psychiatrie, Psychosomatik und Psychotherapie
im Kindes- und Jugendalter
z. Hd. Frau Steinhilber
Osianderstraße 14
72076 Tübingen

Mail: direktorat.kjp@med.uni-tuebingen.de

Fax: 07071/ 29-25146

Appointment:

First contact to our clinic? yes no

Name of the child: _____ **Date of birth:** _____

Child lives with parents mother father _____

Contact information mother	Contact information father	Contact information residential group / foster family
Name:	Name:	Name:
Address:	Address:	Address:
Phone:	Phone:	Phone:
Mobil:	Mobil:	Mobil:
Mail:	Mail:	Mail:
Child custody <input type="checkbox"/> yes <input type="checkbox"/> no	Child custody <input type="checkbox"/> yes <input type="checkbox"/> no	Child custody <input type="checkbox"/> yes <input type="checkbox"/> no

Please note: If only one parent attends the appointment, the other parent must agree to the appointment in writing (form p. 3). In the case of separated parents with joint custody, the appointment cannot take place otherwise.



Insurance Information

Insurance: <input type="checkbox"/> private (<input type="checkbox"/> statutory)	
Name of insurance company:	Principal insurer, date of birth:
Video consultation – more information on page 7	
We could imagine that the contacts take place via video. <input type="checkbox"/> yes <input type="checkbox"/> no	Requirement: - Device with camera, microphone (PC, laptop, tablet, mobile phone) - Internet access

Problems / symptoms / pre-diagnosis

Is your child currently taking any medication? yes no
If so, which one and how is it dosed?

Contact with another child and adolescent psychiatrist? yes no
If so, to whom? Does this contact still exist?

Contact with another child and adolescent therapist? yes no
If so, to whom? Does this contact still exist?

Has there already been an inpatient child and adolescent psychiatric stay? yes no
If so, when and where?

Has a test psychology examination already taken place? yes no
If so, where?

If you answered **yes** to one or more questions, please bring copies of the letters or therapy reports to the appointment.



Declaration of consent of the absent parent

I hereby agree that my daughter / son

name of the child: _____ date of birth: _____

will be examined and treated in the Department of Psychiatry, Psychosomatic Medicine and Psychotherapy in Children and Adolescents of the University Hospital Tübingen.

I authorize

the mother / the father: name _____

other persons (e.g. foster parents, residential group): name _____

to consent to the treatment and to make all necessary declarations.

In addition

I authorize her / him, **OR** I **don't** authorize her / him,

to undertake all necessary confidentiality obligations, such as for the pediatrician, other treating therapists, school, youth welfare and so on.

This declaration of consent may be revoked at any time in writing with immediate effect.

Name of the signing person

Date

Signature



Please arrive **20 minutes** before your first appointment and bring copies of the following documents, if available:

- Declaration of consent for the absent parent
- Yellow medical screening book
- Medical / psychosocial reports
- Treatment reports
- Informal school behavior report from the class teacher
- School reports of the last two years
- Youth welfare office reports

Please note that due to construction measures around the site, the parking situation and footpaths are significantly restricted. Please schedule enough time for the arrival.

Thank you for your understanding!



Directions



Arrival by bus:

Bus line 5:

Exit at the bus stop „Kliniken Tal“, cross the road on the other side and follow the signs to „Psychiatrische Klinik“. (footpath about 10 min.)

Bus line 13, 18 & 19:

Exit at the bus stop „Calwer Straße“. Please follow the signs to „Kliniken Tal“/ „Psychiatrische Klinik“. (footpath about 10 min.)

Arrival by car:

You can park along the road of Schnarrenbergstraße or you park at the car park P3 from the women's hospital (inner city clinics, Röntgenweg 2) or the car park „Altstadt König“ and follow the signs for „Psychiatrische Klinik“.

Please note that the staircases at the car park „Altstadt König“ are not available.



More information on page 9

Declaration of consent to video and telephone consultation / confidentiality / contact for study requests

Dear parents, dear patients,

since we care about the best possible diagnosis and treatment of your child, we ask for your consent to the following points, which will make our work easier. Please refer to the back for further explanations.

Name of your child / youth _____, born the _____

For the period of diagnosis / treatment between my child or me and the staff of child and adolescent psychiatry (please mark as applicable)

- I agree to an instant shot of my child.
- I undertake to keep private information confidential to third parties.
- I agree that video and audio recordings may be recorded for diagnostic and therapeutic purposes.
- I agree that the video or audio recordings may be used for supervisory purposes within the child and youth psychiatry.

I agree to be contacted for study requests.

- Contact for study requests

By signing, I acknowledge that each of these declarations has been made voluntarily. I have been informed that I have the right to revoke this statement at any time, informally in writing or orally. Participation in therapeutic measures can of course also take place if I do not agree to the use of the recordings and data.

Tübingen, the _____

Signature of parents / legal guardians

Signature of parents / legal guardians

Signature of child / youth



Information sheet

Declaration of consent

Instant image for the file

The instant image is taken at one of the appointments in our outpatient clinic. The recording is primarily for the recognition of your child. The image is stored in the file during diagnosis and treatment. The images are not saved after completion of the treatment. We will destroy them appropriately. Under no circumstances will personal data be passed on to third parties.

Obligation of confidentiality

As part of the treatment of your child, you may receive information about fellow patients that is very personal and not intended to be passed on to third parties. By signing, you agree to remain silent about this information. The obligation of confidentiality applies throughout and after treatment.

Image and sound recordings

Our clinic has the possibility to take pictures and sound recordings (photos, videos, tape recordings and so on). The records are used in accordance with the applicable data protection regulations and are subject to medical confidentiality.

- Diagnosics and therapy: The primary aim of the image and sound recordings is to improve the quality of diagnosis, assessment and treatment. The quality of the treatment can be improved by a subsequent, precise examination in the interdisciplinary team.
- Supervision and internal teaching: As a university hospital we are a training hospital, which means the training of doctors, therapists, nurses and so on is an important part of our work. Appropriate admission in meetings can contribute to the quality of treatment.

Contact for study requests

We conduct scientific studies to learn more about the causes of psychiatric illnesses and to expand our existing knowledge. This enables us to constantly improve our treatment. You could help us to develop the medical expertise that people with mental disorders can benefit from in the future. We would be happy if we could contact you and your child in line with such studies. An employee would then contact you in order to present the study to you in detail. Our studies are reviewed and approved by the responsible ethics committee. The participation in studies is voluntary. It is possible to refuse to participate in a study at any time – without giving reasons and without restricting health care and rights. You may also revoke your consent to be contacted by us because of the studies at any time. Your data will be treated confidentially and will not be passed on.



Information sheet

Video and telephone consultation

Increasingly, video and telephone consultation are also being used in our company. They represent an additional offer for us. Personal appointments will continue furthermore. When registering and making an appointment, you can indicate whether video consultation is possible and feasible for you. If this is the case, you will usually receive a link via e-mail that allows you to access our video system.

To do this you need an internet-enabled device with microphone and camera. Please also check that your browser settings are enabled for this. Please ensure a quiet and well-lit environment for trouble-free implementation. Participation in the video consultation is voluntary and the use of the software is free of charge.

The program through which the video consultation is carried out is certified and approved by the health insurance companies. Data collection, processing and use for video consultation is carried out in accordance with the *Agreement on the Requirements for Technical Procedures for Video Consultation in accordance with Annex 31b to the Federal Coat Agreement – Doctors SGB V*.

We inform you hereby:

- The participation in the video consultation is voluntary for me / my child and staff of the clinic.
- To ensure data security and trouble-free operation on both sides, the video consultation takes place in enclosed rooms that ensure adequate privacy.
- At the beginning of the video consultation session there is a presentation on both sides of all the persons present in the room.
- Recordings of any kind are not permitted during video consultation.
- During the consultation, the employees inform the participants according to the requirements for the conduct of the video consultation (according to § 3 of the *Agreement on the Requirements for the Technical Procedures for the Video Consultation Hours according to Appendix 31 b of the Federal Coat Agreement – Doctors SGB V*).
- You consent to the collection, processing and use of my health data in the context of the video consultation by employees of the clinic; always in accordance with the applicable data protection regulations.
- You can revoke the consent of the employees of the clinic at any time without special formal requirements and deadlines.