Clinician of Record's Agreement to Exchange Information

I understand that my patient _____ is seeking to participate in the National Institute of Mental Health (NIMH) sponsored research study, ***Preventing Perinatal Depression: Developing Tools and Interventions (PRE-D)***, in the Department of Psychiatry at UT Southwestern. She signed a two-way release to authorize communication between my office and the PRE-D staff, who are available to answer questions.

Background: The **research aim** is to develop a program for women who are attempting conception or are pregnant, and are at risk for depressive relapse and recurrence. All patients will receive psychiatric evaluation and regular clinician assisted internet (or telephone) monitoring of depressive symptoms. In addition, half of the patients will be randomized to a new intervention called Preventive Cognitive Therapy (P-CT). This intervention is based on cognitive therapy, a well-validated treatment for depression and has been shown to reduce depressive relapse. Patients will also receive education on preconception planning (when necessary) and will undergo follow-up evaluations. The internet (or telephone)-based delivery of these monitoring and potentially preventive tools is designed to be convenient for patients and clinicians.

Because these tools are under development, the PRE-D staff requests feedback from you and your patient on how to improve the program and best meet your needs.

☐ I/or my designee agree to receive communication from the PRE-D research staff regarding my patient's depressive symptoms and psychosocial status. If I do not agree my patient will not qualify for participation due to safety considerations.

☐ I/or my designee will provide feedback of the study tools and resources. (Not required for your patient to participate).

☐ (If applicable), I agree to help my patient withdraw from antidepressant medications and I will work with PRE-D research staff to establish a start date for medication tapering.

Designee: _____ Tele: _____ Email: _____

_____

Name of Clinician of Record (Please Print Clearly)

_____ _____

Signature of Clinician of Record Date

Please hit send or fax to (214) 648-5340: Psychosocial Research and Depression Clinic, c/o Robin B. Jarrett, Ph.D., Professor of Psychiatry, 214-648-5345, The University of Texas Southwestern Medical Center at Dallas, 5323 Harry Hines Blvd., Dallas, TX 75390-9149.