CONSENT FORM FOR EMERGENCY DEPARTMENT DISCHARGES

[NAME HOSPITAL] is currently working with the *CRISIS HOTLINE of [CENTER]* to provide telephone follow-up services to individuals evaluated in our emergency department or on observation on the inpatient unit for any suicidal thoughts or behavior. We believe this telephone follow-up service could be helpful to you and support you in your recovery.

The [CRISIS CENTER] is 24 hours per day, 7 days per week mental health crisis hotline for [LOCAL AREA] and is funded by the Alcohol, Drug Addiction and Mental Health Services Board of [LOCAL AREA]. They have been providing mental health crisis services for the past 15 years.

As part of this follow up program, the [CRISIS CENTER] will provide supportive phone calls to you following your discharge from our emergency department or inpatient unit. These calls may include (but are not limited to) emotional support, ongoing assessment of your mood and thoughts of suicide, and assistance with the development of a plan to keep you safe.

If you consent to participate in this program, you will receive your first call from the [CRISIS CENTER] within 24 hours of your discharge from the ED. The [CRISIS CENTER] will contact you thereafter at a minimum of 2 times per week (depending on need) until such time as:
(a) You are connected to appropriate care and/or are no longer in need of crisis line follow up
(b) The crisis line is unable to reach you and has made a minimum of three attempts

The confidentiality of any information disclosed during a call to the [CRISIS CENTER] will be upheld at all times. If the [CRISIS CENTER] wishes to share your information with others that can assist in your care, they must obtain your permission to do so. The only exception to this rule is if your life is in danger: In this case, the [CRISIS CENTER] may share information about you with individuals or agencies they believe can assure your immediate safety.

You can terminate involvement with the [CRISIS CENTER] follow-up program at any time. You are also free to contact the [CRISIS CENTER] directly at any time during or after your formal involvement in the follow up program.

I have read and understand the program description provided above.

- ❑ **Yes,** I would like to participate in the follow up program. I give consent for the *NAME HOSPITAL* to provide the *CRISIS CENTER* with protected health information relevant to my care. Fax form to XXX-XXX-XXXX.
- ❑ **No,** I would <u>not</u> like to participate in the follow up program. I <u>do not</u> give consent for *NAME HOSPITAL* to provide the *CRISIS CENTER* with protected health information relevant to my care. Fax form to XXX-XXX-XXXX.

Patient	**Hospital Staff Member**
Signature:	Signature:
Name:	Name:
Date:	Date: