CONSENT FOR SPECIALIZED PROCEDURES

NORTH DAKOTA DEPARTMENT OF HUMAN SERVICES
FIELD SERVICES
SFN 27 (9-2021)

Clear Fields

Client Name	Client ID	Date of Birth
Episode	Admission Date	Current Date

I consent to participate in an audio/video recording for the purpose of supervision.
☐ Yes ☐ No

I understand that these recorded materials will not become part of my clinical record. These materials will be stored in a secured area until their purpose has been served, at which time they will be destroyed, no longer than six months from date of recording. I understand that:

- I am not required to be audio/video recorded and I am under no obligation to sign this consent form;
- My access to services will not be affected by my decision not to be audio/video recorded;
- I may revoke this consent at any time by submitting a written request to withdraw my permission.

I understand the conditions, and have had an opportunity to have any questions answered.

Signature of Client or Legal Representative	Date

I consent to participate in an evaluation to determine whether I am/remain a sexually dangerous individual.
☐ Yes ☐ No

As part of this evaluation I will be asked to participate in interviews with a qualified expert who has an expertise in sexual offender evaluations. I understand that I may refuse to participate in those interviews or to answer any individual questions. Exercise of the option to not consent or not answer any individual questions will not be prejudicial. In any event, a report will be prepared for the court. I understand that nothing I say or do is confidential and that anything I say is part of the record that may go to the court. I further understand that anything I say or do, noted by the expert, may be documented in my record, and incorporated into the basis for their report. I have read this notice of informed consent or have had it explained to me in terms I can understand. All my questions about it have been answered.

Signature of Client or Legal Representative	Date

I consent for psychiatric medications
☐ Yes ☐ No

I have received the following information from my prescriber for each medication listed below:

- The diagnosis and target symptoms for the medication recommended;
- The possible benefits/intended outcome of treatment, and as applicable, all available procedures involved in the proposed treatment;
- The possible risks and side effects; including risk of medications to pregnant women and women who are breast feeding;
- The possible alternatives and complementary treatments;
- The possible results of not taking the recommended medications;
- The possibility that the medication does and/or frequency may need to be adjusted over time, in consultation with my prescriber;
- My right to actively participate in treatment by discussing medication concerns or questions with my prescriber;

Medications Prescribed

Signature of Client or Legal Representative	Date

I consent to participate in Telemedicine Services. I hereby request to take part in Telemedicine Encounters.
☐ Yes ☐ No

A telemedicine encounter is delivery of health care services over two-way interactive video. I understand that I may be evaluated and treated by a healthcare provider or specialist who is at a different and possibly distant location. I understand that other people may assist that provider or specialist with this encounter. It has been explained to me and I understand that:

- The consulting healthcare provider or specialist will be at a different location from me. A case manager or other healthcare provider ("present") may be at the same location as I am to assist in the consultation. There may also be a technical person to operate the equipment.
- The presenter or another individual who will operate the equipment may transmit or share electronically details of my medical and clinical history, evaluations, or other clinical documents with the provider or specialist who is at a different location.
- I will be informed if any additional personnel are to be present other than: myself, individuals accompanying me, the provider or specialist, the presenter, and the technical person. I will be required to give my permission prior to the entry of additional personnel.
- The healthcare provider or specialist in a different location may request that I visit that provider or specialist in person to further evaluate my condition.

I understand that I have the right to:

- Refuse or stop participation in the telemedicine encounter at any time.
- Limit any physical examination proposed during the telemedicine consultation, but recognize that a follow-up referral to a local medical or clinical provider may be recommended.
- Request that the presenter not transmit my medical information, if I make the request in writing before that information is transmitted.
- Request that non-medical personnel leave the room at any time.
- Request that all personnel leave the room to allow me a private consultation with the provider or specialist at the different location.

I agree that any questions I have about the telemedicine encounter have been answered in a satisfactory manner and consent to participate in telemedicine encounter as described above. While every effort will be made to maintain a good quality audio and video connection, this is some possibility that technology could fail. If the encounter is not successful due to technology failure, a billing for the procedure will not occur.

Signature of Client or Legal Representative	Date

I consent for HIV testing and disclosure of positive results.
☐ Yes ☐ No

1. This blood screening test detects the presence of HIV antibodies.
2. The blood is sent to an outside reference lab for testing.
3. I understand the procedure and possible risks.
4. North Dakota State Hospital may disclose positive results to the following:
    a. Me
    b. Healthcare provider and his/her agent or employee
    c. Blood bank, blood center, or plasma center
    d. A Healthcare provider who procures, processes, distributes, or uses a human body part lawfully donated by me
    e. State health officer or designee for the purpose of epidemiologic surveillance or control of communicable disease
    f. Licensed embalmer
    g. Accreditation body or healthcare services review organization for the purpose of program monitoring and evaluation

Signature of Client or Legal Representative	Date

I request that the North Dakota Department of Human Services (DHS) communicate with me about my protected health information (PHI) by alternative means or at an alternative location.

☐ Agree ☐ Disagree

If you are asking DHS to communicate with you about your PHI by alternative means or at an alternative location, please consider the following:

- PHI is any information created by the Department, or received from a healthcare provider, health plan, or healthcare clearing house, about your health care. Information may include your name, address, birth date, phone number, social security number, Medicare number, health information, diagnoses, medical treatments received, and information on your health insurance policies.
- DHS, as a healthcare provider, will accommodate your request if you provide a reasonable alternative means or location for communicating with you.
- DHS health plans will accommodate your request if it is reasonable and you clearly state that failure to communicate your PHI to the alternative means or location could endanger you.
- You shall provide a satisfactory explanation how any payments (if applicable) will be handled using the alternative means or alternative location that you request if DHS accommodates your request.
- DHS will begin communications to the alternative location withing five (5) business days of receipt of this signed document. Any communications sent prior to this date will be sent using the existing information.
- This request will remain in effect until you notify DHS in writing requesting a change.
- If your request is for DHS to communicate with you about your PHI via e-mail or text messaging, the limits of e-mail, text messaging, or DHS computer systems may limit the amount of PHI DHS can disclose.

I request that my PHI, from a DHS healthcare provider, be communicated by the alternative means or location listed below because contacting me at my current address, telephone number, or both is a safety issue for me. I understand that communications will continue to be addressed to me, but at the alternative means or location indicated below:

Telephone Number	Number for Text Messaging	Email Address		
Mailing Address		City	State	ZIP Code
Other, please specify				

If you are requesting DHS to communicate PHI by e-mail or text messaging, please note that unencrypted e-mail and text messaging is NOT a secure form of communication. There is some risk that any PHI and other confidential information that may be contained in such e-mail or text messages may be misdirected, disclosed to or intercepted by unauthorized third parties. I consent and accept the risk in transmitting PHI and other confidential information via unencrypted e-mail or text messaging.

Signature of Client or Legal Representative	Date