BCRenal
Provincial Health Services Authority

Consent to be Called

PATIENT INFORMATION LABEL

Name: _____

Address: _____

Phone: _____

Date of Birth (MM/DD/YYYY): _____

PHN: _____

I, _____
understand that it is my responsibility to let my hemodialysis unit know if I am unable to attend on a specific day. Hemodialysis unit phone number: _____.

I understand that in the event that I do not show up for dialysis, the staff from the hemodialysis unit will attempt to contact me to check on how I am doing.

If I cannot be reached, please attempt to contact:

	Name	Relationship	Phone Number
☐	_____	_____	_____
☐	_____	_____	_____
☐	_____	_____	_____

If none of the contacts provided are able to reach me:

- ☐ Call the Police/RCMP and request a “well-being” check.
- ☐ Do not call the Police/RCMP to do a “well-being” check. I have been advised that by refusing to allow the Police/RCMP to check on me I will be at increased risk of harm, including death, and I accept that risk.

If my preferences change, I will provide an updated form to my kidney care team.

Agreement
The information provided on this form was discussed with me by a member of my care team. I have had the opportunity to ask questions. I am satisfied with the explanations and understand them.

Signature of: ☐ Patient ☐ Substitute Decision Maker	Print name of Patient /Substitute Decision Maker
Signature of witness	Print name & designation of witness
Date & time signed (day/month/year)	

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Interpreter

I have translated this document to the best of my ability and confirmed with the patient that he/she has no further questions and the contact information above is correct.

Signature of Interpreter

Print name of Interpreter

ID Number

Date signed (day/month/year)

Time (HH:MM)

Review of Agreement

- Review agreement with patient **upon patient request and/or as patient situation changes**.
- If patient changes his/her wishes for follow-up contact (e.g., now does not wish anyone to be contacted), complete new consent. Otherwise note the date of the review below.

Review date	Reviewed By (care team member)