

# TEST, LINK, CALL (TLC) CONSENT AND RELEASE OF INFORMATION FORM

By checking the boxes below and signing on the next page, I confirm that I am eligible to participate in the TLC Project, I understand what is involved, and I agree to the following:

- I confirm that I want to get connected to care for either Hep C, HIV, or Hep B
- I confirm I would like support to help plan and stay connected to medications for Hep C, HIV, or Hep B
- I understand that if I choose to **participate in the TLC Project**, I can receive a cell phone that will have a \$0 rate plan giving me unlimited talk & text in Canada for 6 months after I receive it. I understand that the plan on my cell phone will not continue after the initial 6-month period, and at that time I will be given the option to either join onto a pre-paid plan, or stop using the phone. Either way, the phone will be mine to keep and use as I choose. I am aware that I will not be asked to return the phone.
- I agree that it is my responsibility to keep the phone safe and in good condition. The BC Centre for Disease Control, BC Hepatitis Network and the TLC Project Team are not responsible for repairs to damaged cell phones.
- I agree that if the phone is stolen, it is my responsibility to let my care team know as soon as possible so that the phone plan can be deactivated. I understand that if my care team has not been able to contact me for a period of at least 4 weeks, that my cell phone will be assumed to be lost/stolen, and it will be deactivated and blocked from all cell phone networks in Canada.
- In accepting this phone, I agree to use the phone responsibly, and within the bounds of the law. This means that the phone must not be used for any illegal activity and also must not be used in situations where it is illegal to do so (for example, texting while driving). If I choose to use the phone in one of these ways, I do so at my own risk.
- I understand that by signing this consent form and receiving my new cell phone, I am agreeing to a Peer or Support Worker helping to make referrals for me to services and support for accessing care and treatment.
- I consent to my new cell phone number being shared with a medical treatment provider(s)
- I consent to the release of my Hep C, HIV, and/or Hep B test results to BC Centre for Disease Control, and to treatment providers in the community.

- OPTIONAL:** I consent to my new cell phone number being shared with the following other providers/people (e.g. family member, friend, OAT clinic or Case Worker):

\_\_\_\_\_

*Name and contact number/email*

\_\_\_\_\_

*Name and contact number/email*

\_\_\_\_\_

*Name and contact number/email*

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- I have been given sufficient time and opportunity to ask questions about the information above, and have received satisfactory clarification and advice.
- I consent to participate in the Test, Link, Call (TLC) Project, and agree for my de-identified personal health information to be collected for the purposes of evaluating the impact of TLC Project.

Please assist client to provide the below info (fill in or circle answers as they apply):

<b>What is your first &amp; last name?</b> _____	<b>What is your date of birth?</b> _____ (dd / mm / yyyy)
<b>What gender/s do you identify with?</b> <input type="checkbox"/> Man/boy <input type="checkbox"/> Woman/girl <input type="checkbox"/> Transgender <input type="checkbox"/> Two-Spirit <input type="checkbox"/> Non-binary <input type="checkbox"/> Agender <input type="checkbox"/> Prefer not to answer <input type="checkbox"/> Prefer to self-identify: _____	
<b>Do you identify as an Indigenous person?</b>  <input type="checkbox"/> Yes <input type="checkbox"/> No	<u>If yes, please specify:</u> <input type="checkbox"/> First Nations <input type="checkbox"/> Métis <input type="checkbox"/> Inuk/Inuit <input type="checkbox"/> Other, please specify: _____ Are you interested in receiving a Traditional Medicines bundle? <input type="checkbox"/> Yes <input type="checkbox"/> No
<b>What is your country of birth?</b>  _____	<u>If you were born outside Canada</u> , please specify what your current status is: <input type="checkbox"/> Immigrant (e.g. Citizen, PR, or work permit holder) <input type="checkbox"/> Refugee (e.g. temporary protection visa holder) <input type="checkbox"/> Undocumented (e.g. no legal status in Canada) <input type="checkbox"/> Other, please specify: _____ <input type="checkbox"/> Prefer not to answer
<b>Which health condition/s will you use your phone from TLC to connect to care for?</b> <input type="checkbox"/> Hepatitis C virus ('hep C') <input type="checkbox"/> Hepatitis B virus ('hep B') <input type="checkbox"/> Human Immunodeficiency Virus (HIV) <input type="checkbox"/> Other, please specify: _____ <input type="checkbox"/> Prefer not to answer	

Client Signature

Date signed

Witness, Name and Signature

Date Signed

**EMAIL COMPLETED FORM TO [STBBI\\_pathways@bccdc.ca](mailto:STBBI_pathways@bccdc.ca)**