Moving on...with Diabetes

DCPNS TRANSITION PROJECT CONSULTANT: REFERRAL CONSENT FORM

Referral to the Transition Project Consultant

☐ I **have read** "Moving on…to Adult Care"

☐ I **understand** that the Transition Project Consultant is able to help me (e.g., answer questions, give tips for my adult care visits, connect me with resources/groups, etc.) as I move to and become comfortable with adult diabetes care.

☐ I **understand** that the Transition Project Consultant and my diabetes care teams (paediatric and adult) will share information about our agreed upon "Moving on" plan and my attendance at diabetes care visits during this time.

☐ I **understand** that I will be asked about my "Moving on" experience (what worked well, what can be improved) to help improve the process for other youth/young adults.

☐ I **understand** that I can end my relationship with the Transition Project Consultant at any time, and it **will not affect** my health care in any way.

☐ I **want** to be referred to and contacted by the Transition Project Consultant.

I **prefer** to be contacted by:

☐ Phone **Is it okay to leave a message?** ☐ **Yes** _____ ☐ **No**

☐ Email: _____

☐ Text: _____

Privacy and Confidentiality of Your Personal Health Information

As part of the referral process, **some of your personal health information** (e.g., health card number, contact information, diabetes type, reason for referral, etc.) will be provided to the Transition Project Consultant located at the Diabetes Care Program of Nova Scotia (DCPNS). To help make sure your move to adult care is as smooth as possible, the Transition Project Consultant and your paediatric and adult diabetes teams will share information about your "Moving on" plan and your attendance at diabetes care visits during this time.

The DCPNS takes the privacy and confidentiality of this information seriously and will only collect, use, or share it as permitted or required by law. DCPNS will **only** keep this information for as long as it is needed for the purposes of your "Moving on" experience and the monitoring and evaluation of the Transition Project.

Personal health information **related to your "Moving on" experience** (see above) will be stored securely (e.g., locked cabinet, secure computer server) and only the Transition Project Consultant, your diabetes care teams, and the DCPNS staff who monitor and evaluate the Transition Project will have access to it.

☐ I **understand and consent** to the collection, use, and sharing of my personal health information for the purpose of my referral to the Transition Project Consultant, my "Moving on" plan, and the monitoring and evaluation of the Transition Project.

NAME (PLEASE PRINT)	SIGNATURE	DD/MM/YYYY DATE

FOR MORE INFORMATION ABOUT YOUR RIGHTS REGARDING YOUR PERSONAL HEALTH INFORMATION, CHECK OUT THE DEPARTMENT OF HEALTH AND WELLNESS WEBSITE:
HTTP://NOVASCOTIA.CA/DHW/PHIA/YOUR-PRIVACY.ASP