

Youth Communication List

CONSENT OTHER

Due to the confidential nature of information regarding patient care at Kootenai Behavioral Health Center, each patient is assigned an **identification number** to be used by family, physicians, and other individuals whom the parents identify as important participants in the care process. The ID number will be required in all verbal correspondence to/or regarding the patient. If for any reason this number is misplaced or forgotten, please contact the assigned case manager directly. It is your responsibility to provide this number to any person(s) listed below whom you wish to have contact with your child.

Your identification number is: _____.

Please list yourself and immediate family members and any clergy you wish to have contact with your child during his/her hospital stay. KBHC Staff may be transporting the patient/resident for purposes of medical treatment, consults, or therapeutic outings.

Please indicate if the phone number provided has capacity for video chat and which type.

Date	Name	Relationship	Phone #	Virtual Video Capability
				<input type="checkbox"/> Facetime <input type="checkbox"/> Skype
				<input type="checkbox"/> Facetime <input type="checkbox"/> Skype
				<input type="checkbox"/> Facetime <input type="checkbox"/> Skype
				<input type="checkbox"/> Facetime <input type="checkbox"/> Skype
				<input type="checkbox"/> Facetime <input type="checkbox"/> Skype
				<input type="checkbox"/> Facetime <input type="checkbox"/> Skype
				<input type="checkbox"/> Facetime <input type="checkbox"/> Skype
				<input type="checkbox"/> Facetime <input type="checkbox"/> Skype
				<input type="checkbox"/> Facetime <input type="checkbox"/> Skype
				<input type="checkbox"/> Facetime <input type="checkbox"/> Skype
				<input type="checkbox"/> Facetime <input type="checkbox"/> Skype
				<input type="checkbox"/> Facetime <input type="checkbox"/> Skype
				<input type="checkbox"/> Facetime <input type="checkbox"/> Skype
				<input type="checkbox"/> Facetime <input type="checkbox"/> Skype

Legal Guardian Signature

Date

Patient Identification – Write in or attach patient label

Name:

MRN #:

CSN #:

DOB/Sex:



614500-015

614500-015

- Consent Other