Gambling Treatment Follow-up Project

Participant Consent Instructions for Providers

1. Introduce the project to your new client. Feel free to use your own words to introduce clients to this important project, or use the script below to guide your introduction:

   "[Agency Name] is participating in an exciting project that relies on client feedback to improve treatment services across the state of Oregon. All clients receiving state-funded treatment for problem gambling, gaming, or support as a concerned other in Oregon are being asked to share their experience with an independent Oregon-based research team. Your participation would not only be used to help future clients, but it would also provide extra support for you in the form of periodic check-ins.

   Participation involves completing telephone surveys every few months, focusing on how your treatment has been and what could be done better. Your participation will help improve [problem gambling/gaming/concerned other] treatment for Oregonians. This is entirely voluntary; you can opt out at any time, and it will never affect the care you receive here with me.

   Here is some more information from the evaluation team." [Provide the consent form]

2. Make sure the client checks one of the boxes on the top of page 2 of the consent form indicating:
   ☐ Willing to Participate or ☐ Do NOT Want to Participate

3. If they consent to participate:

   a. Please ensure ALL fields are accurate and complete.

   b. Encourage the participant to program our contact number into their phone to avoid our calls going to spam or being ignored as an unknown number. (See the bottom of page 2 for a virtual contact card).

      i. Project contact name: Treatment Evaluation Project *(they will be contacted by one of our research team members)*

      ii. Project contact number: ***503-270-3902*** *(Note: This is a confidential line only used for the follow-up project)*

   c. We suggest uploading a copy into the client's chart as the form serves as client consent for you to release information (ROI) or you can choose to obtain a separate ROI.

4. Regardless of whether the client indicated "Yes" or "No", please fax the consent form to the evaluation team at ***1-503-270-3980***.

   If you do not have access to fax, you can send a copy of the completed consent form via your agency's HIPAA-compliant email to ***PG_Tx_Evaluation@problemgamblingsolutions.com*** (make sure this is sent as a secure email).

Consent to Participate: Follow-Up Evaluation

Why Your Participation Matters

- To ensure you and others receive the best care possible, it's important to evaluate services and better understand what factors are related to positive outcomes.
- This evaluation is contracted by the Oregon Health Authority and conducted by a team of clinically trained researchers from Problem Gambling Solutions, Inc., based in Oregon.
- **Your treatment and life experiences are critical for improving programs across the state and furthering our understanding of change.**

What Participation Involves

- Complete brief (10-15-minute) phone interviews with a research assistant
- Phone interviews are scheduled for 30, 90, 180, & 365 days after starting treatment, when leaving treatment, and 180 & 365 days after exiting treatment
- Answer questions on treatment experience, including how you are doing, what you've found helpful, and advice you would give others

Note: Your **contact information is stored separately** from your survey responses. It is used **solely to contact you** and is never shared with anyone outside the evaluation team or your clinician.

Your Privacy and Trust Are a Priority.

- Your name and other identifying information **are confidential**. Unless there is an imminent safety threat to yourself or someone else, your information will never be shared. In these cases of severe risk, we will talk with you about steps to protect against harm.
- Your provider(s) may be aware if you are participating, but will not have access to your responses. We may also communicate with your provider if we believe we have inaccurate information.
- Data is stored in password-protected, secure files.
- We expect that, sometimes, other people may have access to your phone. We will always verify your identity before sharing any details about the nature of the call.

By consenting to participate in this project, you consent for your counselor to fax the completed form to our evaluation team and understand that a member of the evaluation team will contact you within one week to discuss the project with you in more detail, address any questions you have, and welcome you into the project. During your project participation, you can decline to answer any questions that may cause you discomfort, and **you can opt out of the evaluation project at any time, and it will not affect your ability to receive care.**

Scan the QR code for an **informational video**

Scan the QR code for the **project contact information**

The portion below is for the client to complete.

Please check the box below to indicate if you're willing to take part in a follow-up evaluation to help improve gambling treatment in Oregon.

☐ Willing to participate. I consent to sharing the information on this form with Problem Gambling Solutions, Inc.

☐ Do NOT Want to Participate (STOP here if client declined to participate)

Name:

Signature: Date: Click or tap to enter a date.

If you consent to participation, please complete the following fields:

Cell phone number: Email:

Is it okay to leave a voicemail with a callback number? ☐ **Yes** / ☐ **No**

Is it okay to send you text messages for setting appointments and providing reminders? ☐ **Yes** / ☐ **No**

Is it okay to send you email messages for setting appointments and providing reminders? ☐ **Yes** / ☐ **No**

Would you be willing to participate in future research on gambling-related issues? ☐ **Yes** / ☐ **No**

If yes, we won't share your contact information. You would be permitting us to contact you to make you aware of research opportunities, and if you were interested, you would need to take the initiative to contact the researcher to learn more and potentially sign up to participate in the project.

The portion below is for the provider to complete.

Clinician name _____ Client PG NET ID#: OR-CLNT-S _____

Make sure to input their PGNet ID, not an agency ID or case number. PGNet ID's begin with OR-CLNT.

Agency name: _____

Client type: ☐ Gambling ☐ Gaming ☐ Concerned other

Client date of birth (MM/DD/YYYY): ____/_____/____

Once complete, please fax this sheet to 1-503-270-3980

Updated July 2025