NW Peace FASD Network
Diagnostic Clinic Coordinator
#204, 9805 97St,
Grande Prairie, AB, T8V 8B9

P 780-533-5444
F 780-533-5455
jen@nwfasd.ca

(Please mail, fax, email, or deliver this referral form to the FASD Clinic Coordinator at the above information)

NW PEACE ALBERTA FASD NETWORK DIAGNOSTIC SERVICES REFERRAL FORM FOR POTENTIAL CLIENT

Date of Referral: _____ *Month/DD/YYYY*

Referred By: _____ *Name/Agency*

Relationship: _____

Phone: _____ **Fax:** _____

Email: _____

Address: _____ (*Street, PO Box, Town/City, Postal Code)*

Consent for Service

As part of my application for service, I hereby consent that the NW FASD Network and Diagnostic team are authorized to collect, view, and store my personal information. The purpose of collecting the information by the FASD Network is to determine eligibility for services as well as provide services in FASD diagnostics. This information is being collected under the Authority of Section 33(c) and Section 34(1)(k)(i) of the Freedom of Information and Protection of Privacy (FOIP) Act. As well as Section 20 (b) and Section 27 of the Health Information Act. Your personal information is protected by the privacy and disclosure provisions of these Acts. If you have any questions about the collection, use and disclosure of your personal information, visit www.cityofgp.com or phone the Legal Services Coordinator at 780 357 7523.

Client Information		
Name of Referred Client (*first, middle, last)*	Date of Birth (*Month/DD/YYYY*): / /	Age (years):
Name of Caregiver(s):		
Relationship to Client (*birth/adoptive/foster parent, maternal/paternal grandparent, etc):*		
Address (*Street, PO Box, Town/City, Postal Code):*		
AHC#:	Email:	
Phone Number:	Alternative Contact:	
Do you identify as: (circle one) Immigrant/Refugee Indigenous/First Nations/Inuit Métis All Other	Do you identify your community as: (circle one) Rural, Urban, Remote, On Reserve, On Métis Settlement	

Legal Information		
Legal Guardian's Name (list **ALL legal guardians** names):		
Address of Primary Guardian		Phone:

1. Why are you requesting an assessment at this time? What do you know about this person that makes you suspect he/she might have a Fetal Alcohol Spectrum Disorder (FASD)? (e.g. behavior problems, cognitive problems such as learning and memory, social skills problems, birth defects)

2.

Is the client aware of the referral?	☐ Yes	☐ No
Is the legal guardian aware of the referral?	☐ Yes	☐ No
Is the parent(s) aware of the referral?	☐ Yes	☐ No

3. Is pre-natal alcohol exposure suspected, and why?

4. Is there <u>documented</u> confirmation of maternal drinking and/or exposure to drugs? (e.g, Birth Mother, Birth Records, CFSA Records.) If not, how might this confirmation be obtained?

5. Is the individual currently enrolled in an educational program? If so, where?

6. Do you consent to referral information for yourself or your child being exchanged with the following sources for the purposes of the referral process? <u>If so, please initial below:</u>

School District/Staff of Educational Program: ☐

7. What previous diagnoses have been received (i.e. ADHD, Anxiety, Depression, etc) and/or what previous assessments have been completed (e.g. psychological, speech, occupational therapy, school, medical/neurological, mental health, judicial)?

Diagnosis OR Assessment Type	Name of Assessor	Who can be contacted for more information?

Consent

Request for assessment through the NW FASD Clinic is reviewed on a case by case basis.

I understand why I have been asked to disclose identifying health information, and I am aware of the risks or benefits of consenting or refusing to consent, to the disclosure of identifying health information as part of the FASD assessment process.

I understand that I may revoke this consent in writing at any time. I understand that this information will be forwarded to the diagnostic physician and/or health clinic only. I understand that the data may be entered anonymously for statistics keeping and research. A photocopy or facsimile of this consent shall be valid as the original.

Disclaimer:
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_____ _____

Signature of Client or Guardian Date

_____

Signature(s) of additional Guardians

If this client is under the age of 18 years the parent/guardian that has parental decision-making abilities must give consent. If this is shared between two parents *both* parents must give consent in order for the assessment to take place.

_____ Name of person completing form (If different from previous info)

Please send completed form by email to jen@nwfasd.ca **or** fax to 780-533-5455 **or** deliver/mail to:

Northwest Peace FASD Clinic at 204, 9805 97 Street, Grande Prairie, AB, T8V 8B9

Northwest Peace FASD

Confirmation of Exposure to Alcohol (Pre-Natal Alcohol Exposure)

Client: _____

Confirmed By: _____

Relationship to Client: _____

Date: _____

Biological Mother Name: _____

Did Bio Mother drink during alcohol during 1st Trimester? Yes_____ No_____
(1st Trimester starts the last day of menstrual period and ends the last day of the 13th week, about 3 months.)

If client's mother drank alcohol at this time, how often and how much was she drinking?:

Everyday_____ 2x –4x a week_____ 1x a week_____ 1-2x a month_____

How Much/How Many Drinks?_____ Type of Alcohol (if known) _____

Did Bio Mother drink during alcohol during 2nd Trimester? Yes_____ No_____
(2nd Trimester starts the 14th week and lasts through the 27th week, about 3-6.5 months.)

If client's mother drank alcohol at this time, how often and how much was she drinking:

Everyday_____ 2x –4x a week_____ 1x a week_____ 1-2x a month_____

How Much/How Many Drinks?_____ Type of Alcohol (if known) _____

Did Bio Mother drink during alcohol during 3rd Trimester? Yes_____ No_____
(3rd Trimester starts the 28th week, 7th month until the end of labor.)

If client's mother drank alcohol at this time, how often and how much was she drinking:

Everyday_____ 2x –4x a week_____ 1x a week_____ 1-2x a month_____

How Much/How Many Drinks?_____ Type of Alcohol (if known) _____

I confirm the above statements to be true to the best of my recollection:

_____ _____
Signature Date

_____
Print Name

_____ _____
Signature of Witness Date

_____
Print Name

Mail: 204, 9805 97 Street, Grande Prairie, AB, T8V 8B9 Phone: 780-533-5444 Fax : 780-533-5455 jen@nwfasd.ca Website: www.nwfasd.com

Updated : April 4, 2019

NW Peace Alberta FASD Network
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CLIENT CONSENT FORM

I, _____ having received services from _____
(Print client name) (Name of Agency)

hereby authorize the service provider to release my information to the NW FASD Network for the purpose of diagnostic services and assessment.

I acknowledge that I have been made aware of the reasons for the disclosure of the above information, and the risks and benefits associated with consenting to its release.

I understand that I may revoke my consent at any time, by providing a signed written statement to that effect.

Date:_____ Valid Until:_____

_____ _____
Signature of Client/ Parent/Legal Guardian Date

_____
Print Name

_____ _____
Signature of Witness Date

_____
Print Name

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ASSESSMENT AND DIAGNOSTIC SERVICES
CONSENT TO RELEASE INFORMATION

I _____ (full legal name of individual or legal guardian), hereby authorize the Northwest Alberta Fetal Alcohol Spectrum Disorder Network Diagnostic Team to exchange information gathered during assessments and intake for _____ (full legal name of individual if different from above).

This information is to be exchanged between the following identified sources:

- Speech Language Pathologist
- Psychologist
- Occupational Therapist
- Physician/Pediatrician
- Public Health Nurse
- Diagnostic Coordinator
- Community Resource Advocate
- Other_____

I authorize the Northwest Alberta Fetal Alcohol Spectrum Disorder Network Diagnostic Coordinator to release this information to the following identified sources:

- School Division _____
- Family Physician _____
- FASD Mentor/Support Worker _____
- Gov't Agencies (AISH, PDD, FSCD, CRA/Disability Tax Credit, AHS, etc.)_____
- Other (Counsellor, Justice System/Addictions/Community Worker, etc) _____

This consent form is valid for the entire time that the client is receiving services from the NW Alberta FASD Network. However, consent can be withdrawn at any time by the client.

_____ _____
Signature of Client/ Parent/Legal Guardian Date

_____ _____
Signature of Witness Date

Updated April 4, 2019

Alberta Health Services

Name *(last, first)*		
Birthdate *(yyyy-Mon-dd)*		
PHN#	HRN#	CoMIS#

Consent to Disclose Health Information

The patient/client or his/her authorized representative must complete this form before AHS may disclose the patient's/client's health information to someone else *(unless Alberta's Health Information Act authorizes disclosure without consent)*. The information on this form, together with any record authorizing a representative to act on behalf of the patient/client, is being collected under part 3 of the Health Information Act for the purpose of recording the patient's/client's consent to the specified disclosure and will be filed on the patient/client record. For questions about this collection of information, contact the program area that provided you this form or contact the Chief Privacy Officer at 10301 Southport Lane SW, Calgary, AB T2W 1S7 or call 1.877.476.9874.

Patient/client name			
Date of birth *(yyyy-Mon-dd)*	Personal health number *(authorized by HIA s.21(1))*		
Address	City/Town	Province	Postal Code
Details of health information being disclosed *(write in full without abbreviations, include dates of treatment)*			

Identify below where records exist

Health service provider, hospital, clinic, program	City/Town
Date consent is effective *(yyyy-Mon-dd)*	Expiry date *(valid for 2 years if no date)* *(yyyy-Mon-dd)*

Name of individual(s)/organization(s) information is being disclosed to: NW Peace FASD Network

Phone	Address	City/Town	Province	Postal Code
780 533 5444	#204, 9805 97st	Grande Prairie	Alberta	T8V 8B9

Purpose(s) of disclosure

Authority of person(s) giving consent *(If signing on behalf of the patient/client, indicate your authority below and provide a copy of the document which authorizes you)*

☐ **Guardian (or Trustee)** - of a minor under the age of 18 years, who is not determined to be a mature minor - named in a Guardianship Order/appointed under the Adult Guardianship and Trusteeship Act, if access to health information relates to the powers and duties of the guardian (or trustee)
☐ **Nearest relative under Mental Health Act** - if access to health information is necessary to carry out obligations of the nearest relative
☐ **Agent** - appointed in an enacted personal directive according to the Personal Directives Act
☐ **Personal representative** - of a deceased patient, if the access to information relates to administration of the individual's estate
☐ **Power of attorney** - if access to health information relates to the powers and duties of the attorney
☐ **Written authorization** - any written authorization from the individual to act on the individual's behalf
☐ **Specific decision maker** - as defined in the Adult Guardianship and Trusteeship Act

I authorize AHS to disclose the health information described above to the individual(s) or organization(s) identified above. I understand why I have been asked to disclose my individually identifying information. I am aware of the risks and benefits of consenting, or refusing to consent, to the disclosure of my health information. I understand that I may revoke this consent in writing at any time.

Name of person giving consent	Signature	Date *(yyyy-Mon-dd)*

NW Peace FASD Network
Community Resource Advocate
Grande Prairie, Alberta
P 780-533-5442
F 780-533-5462
JenR@nwfasd.ca

Northwest Peace FASD

NW FASD CLIENT CONSENT TO RELEASE FORM

I, _____ (full legal name of individual or legal guardian)

hereby authorize the Northwest FASD Network to release information for the purposes of follow-up

support services for: _____ (full legal name of individual).

This information may be exchanged between the following identified sources:

- FASD Mentor/Support Worker _____
- Education _____
- Health _____
- Parenting _____
- Legal _____
- Family and Community Support Services _____
- Gov't: AISH, PDD, Mental Health, FSCD, Disability Tax Credit, etc. _____
- Other _____
- Other _____

I acknowledge that I have been made aware of the reasons for the disclosure of the above information and the risks and benefits associated with consenting to its release.

I understand that I may revoke this consent at any time, by providing a signed written statement to that effect.

_____ _____

Signature of Client/ Parent/Legal Guardian Date

_____

Print Name

_____ _____

Signature of Witness Date

_____

Print Name

* This information is confidential and should not be copied, duplicated, or given to another party without the express consent of the client or legal guardian.