NWR FASD Society: Mackenzie Network
PO Box 3668, 10502 103 street
High Level, AB, T0H1Z0
Office: (780)926-3375
Fax: (780)926-3376

Adult FASD Clinic Referral

Today's Date: _____

Full Legal Name:	
Date of Birth: *(month/day/year)*	
Address:	
Contact Info: Home Phone	Cellphone *(Call or Text)*
Personal Health Care Number:	Location/Hospital of Birth:
Birth Mother's Name:	
Birth Father's Name:	
Is the individual aware of this referral? ☐ Yes ☐ No	

Name of Individual Making Referral:	
Agency:	
Contact Info: Phone	Cellphone *(Call or Text)*
Email:	
Relationship to client: ☐ Birth Parent ☐ Caregiver ☐ Support Worker ☐ Other *(specify)*	

Why is an FASD assessment being requested?
Please explain all areas of concern and behaviours that lead you to believe they may have FASD

Has there been Confirmation of Prenatal Alcohol Exposure?
☐ Yes ☐ No

Who/what is the source of confirmation?
☐ Birth Mother ☐ Birth Father ☐ Other Relative ☐ Medical Records ☐ Other _____

Provide Contact Information for the Confirmation of Prenatal Alcohol Exposure (PAE)
Name, Contact info and Relationship to Client

Are they aware that we will contact them for Confirmation of Prenatal Alcohol Exposure (PAE)
☐ Yes ☐ No

Are there any previous Diagnosis?
(ADHD, Bipolar, Anxiety, etc.)

Are there any other Services, Supports or Agencies that are currently involved with the client and their family?

Name:
Agency:
Contact Info:

Please add any additional information you think would be helpful?

How urgent is the need for assessment and diagnostic services?
☐ Critical ☐ High ☐ Medium ☐ Low
Please provide rationale

******Office Use Only******

Received by: _____ ***Date:*** _____

Alberta Health Services

Consent to Disclose Health Information
Health Information Act

The patient/client or his/her authorized representative must complete this form before Alberta Health Services (AHS) will disclose the patient's/client's health information to someone else (unless Alberta's *Health Information Act* authorizes disclosure without consent).

Section A: Patient/Client Information

Patient/Client Name

Date of Birth *(yyyy-Mon-dd)*	Personal Health Number

Section B: What health information do you want disclosed?

Please provide details about the health information you want disclosed, such as the name of the AHS location/facility that provided the health service and the time period of the records.

ALL PRE-NATAL, BIRTH RECORDS, DISCHARGE SUMMARIES and ANY INFORMATION REGARDING ETOH USE.

Section C: What individual/organization is the patient's/client's health information being disclosed to?

Name of Individual/Organization			Email	
NWR FASD Society - Kimber Lepensee or Wanda Beland			clinic@nwr-fasd.ab.ca	
Address	**City/Town**	**Phone**	**Province**	**Postal Code**
PO Box 3668 - 10502 103st	High Level	(780) 926-3375	AB	T0H1Z0

Section D: What is the purpose for disclosure?

Please provide the reason why you want to disclose the health information *(required)*.

FASD ASSESSMENT AND DIAGNOSIS

Section E: Authorized Representative *(required when asking for health information on behalf of another person)*

If you are signing on behalf of the patient/client named in section A, please choose one of the options below and provide a copy of supporting documents.

- ☐ **parent** or **legally appointed guardian** of the patient/client who is under 18 years of age and who is not a mature minor in relation to their health information.
- ☐ **guardian** or **trustee** appointed for the adult patient/client under the *Adult Guardianship and Trusteeship Act* exercising my powers or duties as their guardian or trustee.
- ☐ patient/client's **agent** named in an activated Personal Directive under the *Personal Directives Act* exercising my authority set out in the Personal Directive.
- ☐ **nearest relative** of a deceased patient/client as defined in the *Personal Directives Act*. **Also complete Section F.**
- ☐ **personal representative** of a deceased patient/client appointed by the patient/client's will or by the Court, administering the patient/client's estate.
- ☐ patient's **named attorney** in a Power of Attorney currently in effect exercising my powers and duties conferred by the Power of Attorney.
- ☐ patient/client's **nearest relative** selected in accordance with the *Mental Health Act* carrying out my obligations as the nearest relative. **Also complete Section F.**
- ☐ patient/client's **specific decision maker, supportive decision maker, or co-decision maker**, authorized in accordance with the *Adult Guardianship and Trusteeship Act* carrying out the related duties.
- ☐ **person with written authorization** from the patient/client to act on their behalf.

Section F: What is your relationship to the patient/client?

I am the _____ *(insert relationship)* and confirm that to the best of my knowledge, I am the nearest relative ranked in the order of authority as indicated in the applicable legislation.

Section G: Consent for Disclosure

I authorize Alberta Health Services to disclose the patient/client's health information described above to the individual or organization(s) identified above. I understand why I have been asked to disclose my health information and I am aware of the risks and benefits of consenting or refusing to consent. I understand I may revoke this consent in writing at any time.

Date consent is effective *(yyyy-Mon-dd)*	Expiry date *(yyyy-Mon-dd)(valid for 2 years if no date provided)*

Name of person giving consent *(Please print)*	Phone

Signature	Date *(yyyy-Mon-dd)*

Information on this form and the supporting documentation are collected under the authorization of sections 20 - 22 of the *Health Information Act* for the purpose of responding to your request and will be filed on the patient/client record. If you have questions about the collection and use of any information on this form, contact the Disclosure Help Line at 1.855.312.2265.

Office Use Only - This form is not to be used to document a disclosure or release of information. Information released must be documented in accordance with section 41 of the *Health Information Act*.