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

Adult Referral for FASD Assessment

Today's Date: ___________________________

Full Legal Name:	
Date of Birth: *(month/day/year)*	
Address:	
Contact Info: Home phone	Cellphone *(Call or Text)*
AB Health Care Number:	Treaty or Metis Number:

Name of Person Referring:		
Agency:		
Phone:	Cellphone:	Alternative:
Email:		
Relationship to client: ☐ Birth Parent ☐ Caregiver ☐ Support Worker ☐ Other *(specify)*		

Birth Mother's Name:
Birth Father's Name:
Mandatory   Who will provide confirmation of Prenatal Alcohol Exposure? *(Please provide relationship to client & contact info)*

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

Received by: ____________________ *Date:* __________________

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Consent to *Obtain/Release* Information

I, ______________________________ hereby give permission to the Northwest Regional FASD Society: Mackenzie Network, to receive information verbally or in writing from the following:

- ☐ Birth Records
- ☐ Mental Health Records
- ☐ School Records
- ☐ Psychological Assessments
- ☐ Health Records
- ☐ Addiction Records
- ☐ Children Services Records
- ☐ Justice Records
- ☐ Speech/Language Assessments
- ☐ Other ____________________

Purpose of the information: This information will be used to assist the Northwest Regional FASD Society and the Diagnostic, Assessment and Intervention Services Team to determine a diagnosis, develop recommendations and make referrals.

The Medical Report and the Neuropsychological Report can be given to the following:

- ☐ Physician
- ☐ Schools
- ☐ Services Agencies
- ☐ Other ____________________
- ☐ Guardian /Trustee
- ☐ Employment Agencies
- ☐ NWR FASD Society

I understand why I have been asked to disclose my information, and I am aware of the risks or benefits of consenting, or refusing to consent, to the disclosure of my information. This consent form is to be effective for the duration of the client's involvement with Diagnostic, Assessments and Intervention Services and may be withdrawn, by written notice, from the client at any time.

Client's Full Name: ____ Date of Birth: ________________

Alberta Health Care Number: ______________________ Hospital of Birth: ________________________

Birth Mother's Name: ______________________________________ Mother's DOB: ________________

____ ____

Signature of Client *Print Name*

____ ____

Witness *Date*

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Consent to Disclose Health Information

Client's Full Name			
Date of Birth *(month/day/year)*		**Alberta Health Care #**	
Address	**City**	**Province**	**Postal Code**

Details of Health information to be disclosed:

All pre-natal, birth, post-natal (1 year old) records, discharge summary, letters, nursing notes and any information regarding ETOH. *(all medical info)*

**** Identify below where Client's Birth & Health records exist ****

Hospital, Nursing Station or Clinic	**City/Town**
Date consent is effective *(month/day/year)*	**Expiry date** *(valid for two years, if no date)*

Organization information is being disclosed to:
Northwest Regional Fetal Alcohol Spectrum Disorder Society: Mackenzie Network
Diagnostic Clinic Coordinator
PO Box 3668, 10502 103street, High Level, AB, T0H1Z0

Purpose(s) of disclosure:

To be assessed through the Fetal Alcohol Spectrum Disorder diagnostic clinic.

I authorize *(agency/organization)* **NWR FASD Society: Mackenzie Network** to disclose the information described above to the individual or organization 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 personal information.
I understand that I may revoke this consent in writing at any time.

Client's Full Name: ______________________ Client's DOB: ______________

Client's Alberta Health Care Number: ______________

Birth Mother's Name: ______________________ Mother's DOB: ______________

______________________ ______________________
Signature of Client *Print Name*

______________________ ______________________
Witness *Date*