Primary Care Network NORTHWEST
11202 – 100 Ave, High Level, AB T0H 1Z0 780-841-3253

Child/Youth Referral for FASD Assessment

(Please send this form by mail, fax, or email to *Cheryl Cunningham-Burns, RSW – FASD Clinic Coordinator*)

PHONE: 780-841-3253 FAX: 780-926-7393 EMAIL: cheryl.cunningham-burns@albertahealthservices.ca

Today's Date: _____

Child's Legal Name: _____ Male Female

Child's Date of Birth: Month _____ Day _____ Year _____

Which hospital was the child born in? _____ PHN _____

Caregiver's name: _____ Relationship to child: _____

Home phone: _____ Cell phone: _____

Mailing address: _____

Physical address: _____

School _____ Teacher _____ Grade _____

Name of person completing this referral: _____

Contact Phone: _____

What is your relationship to the child? _____

Who has legal signing authority for the child? _____

PLEASE ATTACH A COPY OF THE GUARDIANSHIP ORDER (if applicable)

Phone number for legal signing authority if not already given above: _____

If the referral is not being made by the mother, is she aware of this referral? YES NO

What is her name and phone number? _____ Date of birth? _____

What issues or difficulties is the child experiencing at home and at school? _____

_____

_____

_____

If you are not already receiving support from the FASD Society, would you like to be referred? YES NO

If you have any questions, please call the FASD Clinical Coordinator at 780-841-3253

NORTHWEST PRIMARY CARE NETWORK
11202 100 Ave
High Level, AB T0H 1Z0
Tel: 780-841-3253 Fax: 780-926-7393

Consent for the collection / receipt of personal or confidential information

I, _____, as Legal Signing Authority, hereby grant permission to
(print name of legal signer above) the NWPCN FASD Clinic Coordinator to OBTAIN the following:

- ☒ Birth / Prenatal Records / Disch Summ / Drs letters / Nrsg Notes
- ☒ Health Recs/ Immun./ Growth Chrts
- ☒ Mental Health Records
- ☒ Addiction Records
- ☒ School Records - IPP /any previous assessments
- ☒ Children's Services Records
- ☒ Psychological Assessments
- ☒ Justice Records
- ☐ Other _____

Purpose of the Information: This information will be used to assist the **FASD Diagnostic Team** to determine a diagnosis, develop recommendations, and make referrals.

Consent for the release of personal or confidential information

The Medical Report information can be given to the following:

- ☒ Physician
- ☒ Foster parent (s)
- ☒ Schools
- ☐ Trustee
- ☒ Service Agencies
- ☐ Employment Agencies
- ☐ Other _____

I understand why I have been asked to disclose my/my child's information. I am aware of the risks or benefits of consenting or refusing to consent to the disclosure of my/my child's information. This consent form is to be valid for 1 year. It may be revoked by written notice by the legal signing authority. A copy or facsimile of this form shall be deemed valid as an original.

Guardianship order copy must be attached (if applicable)

Child's Name: _____

Child's AB Health #: _____ Child's Date of Birth: _____

Hospital of birth: _____

Birth Mother's Name: _____ Birth Mother's Date of Birth: _____

_____ _____

Signature of Legal Signing Authority Date:

rev.Oct/14

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, Drs letters, 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		Phone	
NWPCN / AHS - Cheryl Cunningham-Burns		(780) 841-3253	
Address	City/Town	Province	Postal Code
11202 - 100 ave	High Level	AB	T0H1Z0

Section D: What is the purpose for disclosure? Fax (780) 926-7393

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

FASD Assessment

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.

I, _____, am
(insert representative name)

- ☐ the **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.
- ☐ the **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.
- ☐ the patient/client's **agent** named in an activated Personal Directive under the *Personal Directives Act* exercising my authority set out in the Personal Directive.
- ☐ the **personal representative** of a deceased patient/client appointed by the patient/client's will or by the Court, administering the patient/client's estate.
- ☐ the patient's **named attorney** in a Power of Attorney currently in effect exercising my powers and duties conferred by the Power of Attorney.
- ☐ the patient/client's **nearest relative** selected in accordance with the *Mental Health Act* carrying out my obligations as the nearest relative.
- ☐ the 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.
- ☐ a **person with written authorization** from the patient/client to act on their behalf.

Section F: 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	Phone	Email
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.

RANDALL SYMES

WADE RANDALL PH.D.
BRENT SYMES PH.D.

REGISTERED PSYCHOLOGISTS
ASSESSMENT AND CONSULTATION

Consent for Educational/Psychological Assessment

Dear Parent/Guardian:

Your child _____ (Date of Birth: _____) has been referred for an educational/psychological assessment to be administered and/or supervised by a registered psychologist from Randall Symes Psychological Services. The testing may be in-person or through Telepsychology. Telepsychology services are provided via secure internet technology as an alternative to face-to-face meetings and assessments. We use secure video-conferencing technology with encryption to maintain a very high level of confidentiality.

This testing will provide insight into your child's difficulties with learning and/or behaviour. You may be asked to complete questionnaires which are optional, but they are intended to gather information from your perspective. Please note that the questions may not be specific to your child; however, it is important that you complete the forms as thoroughly as possible. Please feel free to add any information that you feel is relevant. All information will be kept in a confidential file and used only for the purposes of this assessment.

Upon receipt of your written consent to conduct the assessment, which may involve a review of your child's student file at their school, arrangements will be made for the evaluation. Your child's teacher may also be asked to complete a package of questionnaires. The results of the evaluation will be shared with you on the date of the evaluation, or shortly thereafter. If you have any questions, please do not hesitate to contact the school or our office at (780) 434-6466.

I give consent for an educational/psychological assessment for the child/adolescent named above.

_____ _____

Print name of consenting person | Relationship to child

_____ _____

Parent/Guardian Signature | Date

TEL. 780 . 434 . 6466 • FAX. 780 . 433 . 5607 • 819 SADDLEBACK ROAD NW . EDMONTON . ALBERTA . T6J 5R4
WADE@RANDALLSYMES.COM • WWW.RANDALLSYMES.COM • BRENT@RANDALLSYMES.COM

RANDALL SYMES

WADE RANDALL Ph.D.
BRENT SYMES Ph.D.

REGISTERED PSYCHOLOGISTS
ASSESSMENT AND CONSULTATION

Authorization to *Obtain/Release* Information

I, _____ hereby give permission for Randall Symes Psychological Services, to ***obtain/release*** confidential information ***and/or*** records pertaining to my child ***and/or*** myself _____ (D.O.B: _____) that would assist in their assessment and/or treatment. These records will be held confidentially by Randall Symes Psychological Services.

Name and address of individual/agency ***from/for*** whom information is to be o***btained/released***:

Name of individual/agency: NWPCN / AHS - Cheryl Cunningham-Burns & Dr. L.Wincott
Address: Northwest Health Centre 11202 - 100ave
City: High Level, AB Postal Code: T0H 1Z0
Phone: (780)841-3253 Name of Contact: _____

_____ _____
Print name of consenting person Relationship to child (if applicable)

_____ _____
Signature Date

This release is valid for one year from the date shown

TEL. 780 . 434 . 6466 • FAX. 780 . 433 . 5607 • 819 SADDLEBACK ROAD NW . EDMONTON . ALBERTA . T6J 5R4
WADE@RANDALLSYMES.COM • WWW.RANDALLSYMES.COM • BRENT@RANDALLSYMES.COM