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 for the Collection of Personal or Confidential Information

I, _____, hereby grant permission to the Northwest Regional FASD Society: Mackenzie Network, to OBTAIN the following:

- ☐ Birth/Prenatal Records
- ☐ Addiction Records
- ☐ Mental Health Records
- ☐ Children Services Records
- ☐ School Records – IPP/Assessments
- ☐ Justice Records
- ☐ Psychological Assessments
- ☐ Speech/Language Assessments
- ☐ Health Records
- ☐ Other _____

The purpose of 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 and the Neuropsychological Report can be given to the following:

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

I understand why I have been asked to disclose my information. 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for the duration of the client's involvement with Diagnostic, Assessments and Intervention Services and may be withdrawn, by written notice, from the client at any time.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: _____

Client's AHC#: _____ Hospital of Birth: _____

Birth Mother's Name: _____ Mother's DOB: _____

_____ _____
Signature of Client *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*.

RANDALL SYMES

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

REGISTERED PSYCHOLOGISTS
ASSESSMENT AND CONSULTATION

Consent for Psychological Assessment

I _____ (Date of Birth: _____) agree to undergo a 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 possible difficulties with learning and/or daily functioning. You may be asked to complete questionnaires which are optional, but they are intended to gather information from your perspective. Please 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.

After receiving your written consent to conduct the assessment we may also review any background information relevant to the evaluation. You will be contacted when the report is complete to arrange a time to share the results with you. If you have any questions, please do not hesitate to contact our office at (780) 434-6466.

I give consent for a psychological assessment to be completed.

_____ _____

Client 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: Northwest Regional FASD Society: Mackenzie Network
Address: PO Box 3668, 10502 103 street
City: High Level, AB Postal Code: T0H1Z0
Phone: (780)926-3375 Name of Contact: Kimber or Wanda

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

_____ _____
Signature Date

This release is valid for one year from the date shown

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