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

Child/Youth Referral for FASD Assessment

Today's Date:____

Child's Legal Name:______________________________ Male Female

Child's Date of Birth: Month ______________ Day __________ Year ______________

Which hospital was the child born? __________________________ AHC# __________

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 contact the FASD Clinical Coordinator

OFFICE: 780-926-3375 **CELL**: 780-926-0450 **EMAIL**: clinic@nwr-fasd.ab.ca

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

Consent for the Collection / Receipt of Personal or Confidential Information

I, ________________________________, as Legal Signing Authority, 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/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 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.

GUARDIANSHIP ORDER COPY MUST BE ATTACHED *(if applicable)*

Client's Full Name: ______________________________________ Date of Birth: _______________

Client's AHC#: _____________________________ Hospital of Birth: _________________________

Birth Mother's Name: _________________________________ Mother's DOB: __________________

____________________________________ _________________________________
Signature of Legal Signing Authority *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 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: NWR FASD Society - Kimber Lepensee or Wanda Beland
Address: PO Box 3668 - 10502 103st
City: High Level, AB Postal Code: T0H 1Z0
Phone: (780) 926 - 3375 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