FASD NETWORK Northwest Central Alberta

Box 5389, Westlock, ab, T9P 2P5
Pediatric Clinic, sharonp@nwcfasd.ca, 780-284-3415 Adult Clinic jennp@nwcfasd.ca, 780-974-7112

PLEASE READ BEFORE FILLING OUT A REFERRAL FORM

The criteria REQUIRED by NWCFASD Network in order to do an FASD assessment are:

Confirmation of Prenatal Alcohol Exposure (PAE) MUST accompany the submission of this referral form and MUST come from one or more of the valid sources listed below:

- **If birth mother is alive, confirmation of PAE MUST come from her.**
- **If the birth mother is deceased and/or cannot be located confirmation of PAE MUST be obtained from the maternal side of the family (excluding current caregiver) and/or from agency file documentation**
- **Biological father or his family CANNOT provide PAE confirmation**

1. Did birth mother consume alcohol in the amount of seven drinks or more per week at least twice during pregnancy? Yes _____ No _____

2. Did birth mother consume four or more drinks at a time on at least two separate occasions during pregnancy? Yes _____ No _____

If you did not answer yes to either of the two questions you do not meet the criteria to have an FASD Assessment done.

If you answered yes to either of the two questions and the confirmed PAE comes from one of the valid sources listed above please fill out the referral form.

Referrals can be faxed to 1-855-962-3273 or emailed to jennp@nwcfasd.ca

If you have any questions, regarding Pediatric Clinic contact sharonp@nwcfasd.ca

780-284-3415, for adult clinic jennp@nwcfasd.ca 780-974-7112

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Assessment & Diagnostics Services Referral Form

Date: _____

Referral Source:

Name: _____

Agency: _____

Address: _____ **Postal Code:** _____

Phone: _____ **Cell:** _____ **Email:** _____

Client Information

Client Name: _____

Male _____ **Female** _____ **Other** _____

Name @ birth (if different from above): _____

Date of Birth: _____ **Health Care Number:** _____

Address: _____ **Postal Code:** _____

Home: _____ **Work:** _____ **Cell:** _____

Hospital at birth: _____

Primary language spoken 1._____ 2._____

Culture Origin: First Nations_____ Metis_____ Inuit_____ Caucasian_____ African American_____

Hispanic_____ Asian_____ Other _____

On Reserve: Yes _____ No _____ **Treaty #** _____ **Band:** _____

Self Identifying: First Nations _____ Metis _____ Inuit_____

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Contact Information

Name of Parents/Caregivers: _____

Address: _____ **Postal code:** _____

Phone: _____ **Cell:** _____ **Email:** _____

Legal Guardian(s): _____

Address: _____ **Postal Code:** _____

Phone: _____ **Cell:** _____ **Email:** _____

Copy of 2 pieces of legal guardian ID enclosed: Yes _____ No _____

Guardianship Enclosed: Yes _____ No _____ NA _____

Current Support or Agency involvement

Name: _____ **Agency:** _____

Address: _____ **Postal Code:** _____

Phone: _____ **Cell:** _____ **Fax:** _____

Email: _____

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Assessment & Diagnostics Services Intake Form

Is Child & Family Services (CFS) currently involved? Yes _____ No _____

If yes, at what level: _____

Caseworker: _____ **Agency:** _____

Address: _____ **Postal Code:** _____

Phone: _____ **Cell:** _____ **Fax:** _____

Email: _____

Has CFS ever been involved? Yes _____ No _____

Family Doctor: _____ **Clinic:** _____

Address: _____ **Postal Code:** _____

Phone: _____ **Fax:** _____

Are there any legal or pending court dates? Yes _____ No _____

If so, please provide details _____

_____

List all the placements the client has had from birth through to age 18

Placement Type	Community	Duration	Client Age	Reason

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Assessment & Diagnosis

Have any assessments been completed to date? Yes _____ No _____

If so attach copies or list assessments and name of the professional involved

_____

_____

Please check all areas of concern with brief explanation:

_____ **FASD related facial features** _____

_____ **FASD related behaviors** _____

_____ **Problems at home** _____

_____ **Problems at school/work** _____

_____ **Work/School Readiness** _____

_____ **Work/School Attendance** _____

_____ **Learning/Academic** _____

_____ **Cognition/Memory** _____

_____ **Fine & or Gross Motor Skills** _____

_____ **Speech/Language** _____

_____ **Social/friends** _____

_____ **Bullying/Cyberbullying** _____

_____ **Substance Abuse** _____

_____ **Trouble with the law** _____

_____ **Sleep** _____

_____ **Suicide attempt/Ideation** _____

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_____ **Health/Lifestyle** _____

_____ **Reproductive Health** _____

_____ **Medical** _____

_____ **Abstract Concepts (time/money)** _____

_____ **Hyperactivity/Impulsivity** _____ **Attention** _____ **Emotional/Mood**

What are the client's strengths and interests? _____

_____

Extra-curricular Activities (sports, hobbies): _____

Cultural Activities: _____

Spiritual/Religious Activities: _____

Current Program Involvement

Does the client currently attend a school or training program? Yes _____ No _____

Name of School of Program: _____ Grade: _____

Is the client currently employed? Yes _____ No _____

Health History

Was the client born with (or later discovered to have) any birth defects (e.g. cleft palate, congenital heart defects, clubfoot, etc.)? Yes _____ No _____ Unknown _____

If yes, please explain _____

_____

_____

Has the client had any Chronic Illnesses?

If yes please explain _____

_____

_____

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Has this client had any surgeries since birth? Yes _____ No _____

If yes, please explain _____

_____

_____

Has the client had any hospitalizations since birth? Yes _____ No _____

If yes, please explain _____

_____

_____

Other historical health related issues

	Yes	No
Physical Abuse		
Sexual Abuse		
Did a physician evaluate this?		
Emotional Abuse		
Neglect		
Witness to Violence		
Other		

Neurological/Mental Health History

Has this client ever had seizures? Yes _____ No _____

Bed wetting or soiling after 8 yrs old? Yes _____ No _____

Is this continuing today? Yes _____ No _____

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Head injury leading to unconsciousness? Yes _____ No _____

CT or MRI scan of brain? Yes _____ No _____

If yes where was this done?_____

Has client ever been diagnosed with ADD/ADHD? Yes _____ No _____

If so, age of evaluation? _____

Treatment prescribed ?_____

List of Current Medications/Treatments:

_____

_____

Pregnancies of Biological Mother (including miscarriage and abortion)

Year	Length of pregnancy	Name of child	Born Alive		Normally Developed		Behavioral/Learning Problems	Other Diagnosis
			Yes	No	Yes	No		

If more space is needed, please use "Additional Information" on page 14

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Family Medical History

	Birth Mother	Birth Father	Birth Mother's Family	Birth Father's Family	Siblings full/half
Alcohol Use					
Alcoholism					
Premature Death related to Alcohol					
FASD					
Birth Defects Related to Alcohol					
Other Birth Defects					
Developmental Delays					
ADD/ADHD					
Autism					
Learning Disorders					
Vision Problems					
Hearing Problems					
Childhood bedwetting					
Seizure Disorders (epilepsy)					
Other medical conditions					
Schizophrenia					

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Family Medical History Continued	Birth Mother	Birth Father	Birth Mother's Family	Birth Father's Family	Siblings full/half
Depression					
Suicide/Suicidal Ideation					
PTSD					
Bi-polar Disorders					
Other Mental Health Issues					
Physical Abuse					
Sexual Abuse					
Childhood Neglect					
Emotional Abuse					
Family Violence Issues					
Trouble with the Law					
Other					

Biological Family History

Birth Mother: _____

Birthdate: _____ **Phone:** _____ **Cell:** _____

At time of Client's birth:

Age: _____ **Marital Status** _____

Living Situation/Accommodations_____

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History of: Learning/Employment Difficulties:_____

Birth Father: _____

Birthdate: _____ **Phone:** _____ **Cell:** _____

History of: Learning/Employment Difficulties:_____

Substance Use History

Describe birth mother's life 1 year before client was born: _____

_____

_____

Describe birth mother's social life at the time at the time of the pregnancy: _____

_____

_____

Did the birth mother have any chronic illnesses, mental health related concerns, stress related circumstances during the pregnancy? If so, please describe:

_____

_____

_____

_____

_____

What types of alcohol (beer, wine, coolers, liquor) did birth mother consume during pregnancy.

_____

_____

What part of her pregnancy was the alcohol consumed? 1st trimester _____ 2nd trimester_____ 3rd trimester_____

How much alcohol was consumed throughout the pregnancy?

1-3 drinks 4-9 drinks 10+ drinks

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How often was alcohol consumed throughout the pregnancy?

Daily Weekly Monthly

What types of and how often were solvents, if any, did birth mother drink during pregnancy. Solvents are things like mouthwash or cleaning supplies that contain alcohol.

_____

_____

Did the birth mother smoke cigarettes during the pregnancy? Yes _____ No _____

How many cigarettes per day? _____

During which part of her pregnancy? 1st trimester _____ 2nd trimester _____ 3rd trimester _____

Did the birth mother use drugs (prescription and/or over the counter) during the pregnancy?

Yes _____ No _____

If so, what type(s)? _____

During which part of the pregnancy? 1st trimester _____ 2nd trimester _____ 3rd trimester _____

Source of this information (full name and relationship to the client) _____

_____

Present Situation

Please describe history of contact with absent birth parents, siblings, maternal extended family and paternal extended family:

_____

_____

_____

_____

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Box 5389, Westlock, ab, T9P 2P5
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List all the persons living in the client's current home and their relationship.

Name	Age	Relationship to Client

FASD Northwest Central Alberta NETWORK

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Additional Information

Fetal Alcohol Spectrum Disorder Network
Northwest Central Alberta
Box 4455 Barrhead, AB T7N 1A3
780-305-8827

FASD NETWORK Northwest Central Alberta

Assessment & Diagnostic Services
Authorization to Obtain Information

I, _____ (full legal name of parent or legal guardian), hereby authorize the Northwest Central Alberta Fetal Alcohol Spectrum Disorder Network to obtain the following information verbally or in writing pertaining to:

_____ (Child's name), _____ (Date of Birth)

Please INITIAL and place an (X) beside the information to be obtained.

- ☐ _____ Birth records and other medical records
  (Including newborn discharge summaries, nursing notes and immunization records)
- ☐ _____ Past and current educational records
- ☐ _____ Speech, language, psychological, and other assessments
- ☐ _____ Children's Services Records
- ☐ _____ Justice or Correctional Services Information, reports and history
- ☐ _____ Mental Health Assessments, reports, and history
- ☐ _____ Other: _____

This information will be used to assist the Northwest Central Alberta FASD Network Diagnostic team to determine a diagnosis, develop continuum of care recommendations and to make appropriate referrals.

This consent form is to be effective for the duration of the client's involvement with the assessment, diagnostic and intervention services and may be withdrawn by the client/legal guardian at any time during this process.

_____ _____
Signature of Parent / Legal Guardian Date

_____
Relationship to Client

_____ _____
Signature of Witness Date

_____
Name of Witness

Legal Guardianship Order attached? Yes _____ No_____ Not Applicable_____

Alberta Health Services

Name *(last, first)*		
Birthdate *(yyyy-Mon-dd)*		
PHN#	HRN#	CoMIS#

Consent to Disclose Health Information

The patient/client or his/her authorized representative must complete this form before AHS may disclose the patient's/client's health information to someone else *(unless Alberta's Health Information Act authorizes disclosure without consent)*. The information on this form, together with any record authorizing a representative to act on behalf of the patient/client, is being collected under part 3 of the Health Information Act for the purpose of recording the patient's/client's consent to the specified disclosure and will be filed on the patient/client record. For questions about this collection of information, contact the program area that provided you this form or contact the Chief Privacy Officer at 10301 Southport Lane SW, Calgary, AB T2W 1S7 or call 1.877.476.9874.

Patient/client name			
Date of birth *(yyyy-Mon-dd)*	Personal health number *(authorized by HIA s.21(1))*		
Address	City/Town	Province	Postal Code

Details of health information being disclosed *(write in full without abbreviations, include dates of treatment)*

Immunizations, nursing notes, all assessments, birth & prenatal records, hospitalizations, discharge summaries, social worker notes, lab reports, outpatient reports, ER visits, all other medical information in the chart.

Identify below where records exist

Health service provider, hospital, clinic, program	City/Town
Date consent is effective *(yyyy-Mon-dd)*	Expiry date *(valid for 2 years if no date)* *(yyyy-Mon-dd)*

Name of individual(s)/organization(s) information is being disclosed to

NWC FASD Network

Phone	Address	City/Town	Province	Postal Code
780-284-3415	Box 5389	Westlock	AB	T7P 2P5

Purpose(s) of disclosure

Clinic assessment and diagnosis of FASD

Authority of person(s) giving consent *(If signing on behalf of the patient/client, indicate your authority below and provide a copy of the document which authorizes you)*

☐ **Guardian (or Trustee)** - of a minor under the age of 18 years, who is not determined to be a mature minor - named in a Guardianship Order/appointed under the Adult Guardianship and Trusteeship Act, if access to health information relates to the powers and duties of the guardian (or trustee)

☐ **Nearest relative under Mental Health Act** - if access to health information is necessary to carry out obligations of the nearest relative

☐ **Agent** - appointed in an enacted personal directive according to the Personal Directives Act

☐ **Personal representative** - of a deceased patient, if the access to information relates to administration of the individual's estate

☐ **Power of attorney** - if access to health information relates to the powers and duties of the attorney

☐ **Written authorization** - any written authorization from the individual to act on the individual's behalf

☐ **Specific decision maker** - as defined in the Adult Guardianship and Trusteeship Act

I authorize AHS to disclose the health information described above to the individual(s) or organization(s) 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 health information. I understand that I may revoke this consent in writing at any time.

Name of person giving consent	Signature	Date *(yyyy-Mon-dd)*

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.

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

Name of Individual/Organization			Email	
Northwest Central FASD Network			sharonp@nwcfasd.ca	
Address	City/Town	Phone	Province	Postal Code
Box 5389	Westlock	780.284.3415	AB	T7P-2P5

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 released of information. Information release must be documented in accordance with section 41 of the *Health Information Act*.

Alberta Health Services

REHABILITATION
Consent for Services

Name: _____

DOB: _____

Phone #: _____

Affix Client's Label here (if Applicable)

☐ **Speech / Language Services** ☐ **Respiratory Therapy Services**
☐ **Occupational Therapy Services** ☐ **Physiotherapy Services**

Please check (√) the appropriate service required (one service only)

Section I – Consent for Services

I, _____ on behalf of _____ consent to:
(Client / Parent / Legal Representative) *(Client's Name)*

a) Participation in an assessment, consultation and/or treatment as may be deemed necessary and that Alberta Health Services – Aspen, Health Service Providers will or may perform such assessment, consultation and treatment. This may include practicum students or colleagues in training.
b) A Health Service Provider, with my involvement, will develop and implement a treatment plan to help reduce my symptoms and improve my ability to function. Treatment may also include coordination of my case plan with other relevant service providers.

I understand that:

c) This consent is effective as of _____ , and expires on the _____
(Day / Month / Year) *(Day / Month / Year)*
d) I may, at any time, refuse to undergo any particular assessment, consultation and/or treatment or accept recommendations for treatment
e) The particular treatment will be undertaken in the Province of Alberta and that the Courts of Alberta shall be the only ones that have jurisdiction to entertain any complaint, demand, claim or cause of action, should the Client decide to commence any such legal proceedings against Alberta Health Services or any of its Affiliates

Signature of: ☐ Client or ☐ Agent or ☐ Guardian
(Note: Agents and Guardians are legal representatives. An agent can only be appointed pursuant to a personal directive)

_____ _____
(Signature) *(Day / Month / Year)*

_____ _____
(Witness Printed Name) *(Witness Signature)*

Section II – Alternate Consent

☐ **Consent has been received, but unable to obtain signature because:** Signature of Health Service Provider

OR

☐ **Telephone** ☐ **Fax** ☐ **Other:**

Name: _____

Legal Status to Client: ☐ Client
or ☐ Other (Specify): _____ _____
(Day / Month / Year)

_____ _____
(Witness Printed Name) *(Witness Signature)*

(One witness (health provider) should confirm consent for Clients unable to sign and fax telephone consent)

The collection of the above individually identifying health/personal information is authorized under the *Health Information Act* and/or the *Freedom of Information & Protection of Privacy Act.* The purpose of the collection allows Alberta Health Services – Aspen to follow up and investigate when appropriate.

Section III – Obtaining Consent of a Non-English Speaking Client

I acknowledge that I have interpreted the contents of this Consent Form to the Client and I believe that the Client understands the contents.

_____	_____	_____
(Interpreter's Printed Name)	*(Signature of Interpreter)*	*(Day / Month / Year)*

Section IV – Consent to Disclose Health Information

I, _____ on behalf of _____
(Client / Parent / Legal Representative) *(Child's Name)*

am hereby authorizing the disclosure of individually identifying Assessment, Consultation, and/or Treatment information for services provided between the specified dates of this consent in Section I. This consent for Disclosure is in accordance with the *Health Information Act.*

This information is to be provided to _____ for the purpose of extended treatment.
(Name of Agency)

I understand that:

a) That the information on this form is collected under the Alberta *Health Information Act* and will be used to comply with this request to disclose the above specified individually identifying health information
b) Why I have been asked to disclose my individually identifying health information, and am aware of the risks and/or benefits of consenting, or refusing to consent to the disclosure of this information
c) **That my consent will be valid as per the specified duration dates in Section I and that it may be rescinded at any time as long as it is in writing by myself or my authorized representative,** and
d) A photocopy or facsimile of this form shall be deemed as valid as an original

_____	_____	_____
(Signature of Client/Parent/Legal Representative)	*(Home Phone Number)*	*(Day / Month / Year)*

_____	_____
(Print Name of Client/Parent/Representative)	*(Relationship to Client – please attach a copy of Authority to Act)*

_____	_____	_____
(Signature of Witness)	*(Printed Name of Witness)*	*(Day / Month / Year)*

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:_____
Address:_____
City:_____ Postal Code:_____
Phone:_____ 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

FASD NETWORK Northwest Central Alberta

Box 5389 Westlock AB T7P 2P5 780-305-9547 or 780-974-7112

Assessment & Diagnostic Services
Consent to Release Information

I, _____, (full legal name of parent or legal guardian) hereby authorize the Northwest Central Alberta Fetal Alcohol Spectrum Disorder Network to release information pertaining to myself and/or my child, _____(Child's name), _____ (Date of Birth) to Jordan's Principle funding of the First Nations and Inuit Health Branch Department of Indigenous Services Canada/Government of Canada and to the First Nations Health Consortium..

Please INITIAL and place an (X) beside the information to be obtained

- ☐ _____ Child's Name
- ☐ _____ Child's date of birth
- ☐ _____ Child's Treaty Status Number
- ☐ _____ Mailing address
- ☐ _____ Documentation of need (psychological assessment, speech language assessment, professional letters of support)
- ☐ _____ Approval of funds being dispensed to NWC FASD Network for Assessment and Diagnostic costs

Parent/Guardian Signature _____ Date _____

Parent/Guardian Name (printed)

_____

Fetal Alcohol Spectrum Disorder Network | Northwest Central Alberta | Box 4455 Barrhead, AB T7N 1A3 | 780-305-8827

FASD NETWORK Northwest Central Alberta

Assessment & Diagnostic Services
Consent to Release Information

I, _____ (full legal name of individual or legal guardian), hereby authorize the Northwest Central Alberta Fetal Alcohol Spectrum Disorder Network to RELEASE the following information verbally or in writing pertaining to:

_____ (Name), _____ (Date of Birth)

This information is to be released to the following identified sources. Please specify the information to be RELEASED by **selecting the corresponding letter** from list below (i.e. A-F) **AND** by placing your **INITIALS** beside each selected item.

A. Assessment & Diagnostic Services Summary Report and Recommendations (Short 1-Page Summary Report)
B. Psychological Assessment Report
C. Speech Language Assessment Report
D. Occupational Therapy Assessment Report
E. Medical Summary Report
F. All Reports Listed Above

Initials	Information	Source
_____	_____	Family Doctor
_____	_____	School Division
_____	_____	Family Supports for Children with Disabilities
_____	_____	Other: (e.g. AMHS, AISH, CFSA, FCSS)
_____	_____	Program evaluation and research

_____ _____
Signature of Client/ Parent/Legal Guardian Date

_____
Relationship to Client

_____ _____
Signature of Witness Date

_____
Print Name of Witness