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________

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: ____

<u>Current Program Involvement</u>

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 _____

<u>Health History</u>

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		

<u>Neurological/Mental Health History</u>

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____

History of: Learning/Employment Difficulties:____

Birth Father: ____

Birthdate: ______________________ **Phone**: ____________________ **Cell:** _______________________

History of: Learning/Employment Difficulties:____

<u>Substance Use History</u>

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

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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List all the persons living in the client's current home and their relationship.

Name	Age	Relationship to Client

Additional Information

FASD NETWORK Northwest Central Alberta

P.O. Box 5389 Westlock AB T7P 2P5
780-284-3415 or 780-974-7112 or 780-305-9547

Assessment & Diagnostic Services
Consent to Release Information

I,____(full legal name of adult client), born____________________________(dd/mm/yyyy) hereby authorize the Northwest Central Alberta Fetal Alcohol Spectrum Disorder Network to RELEASE the following information verbally or in writing.

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

____
Date

____
Signature of Witness

____
Date

____
Print Name of Witness

P.O.Box5389WestlockABT7P2P5
780-284-3415, 780-974-7112 or 780-305-9547

Adult Assessment & Diagnostic Services
Consent to Obtain/Release Information

I,____(full legal name of client), born______________________________(dd/mm/yyyy) hereby authorize the Northwest Central Alberta Fetal Alcohol Spectrum Disorder Network to OBTAIN/RELEASE confidential information verbally or in writing for the purpose of coordinating an assessment and diagnosis, developing 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 at any time during this process.

Name and address of individual/agency(ies) from/for whom information is to be obtained/released:

Northwest Central Alberta FASD Network
Box 5389
Westlock, Alberta T7P 2P5
Contact: Sharon Pearcey

____
Signature of Client

____
Date

____
Signature of Witness

____
Date

____
Print Name of Witness

FASD NETWORK Northwest Central Alberta

P.O. Box 5389 Westlock AB T7P 2P5
780-284-3415 or 780-974-7112 or 780-305-9547

Assessment & Diagnostic Services
Authorization to Obtain Information

I,____(full legal name of adult client),

born_____________________________(dd/mm/yyyy) hereby authorize the Northwest Central Alberta Fetal Alcohol Spectrum Disorder Network to obtain the following information verbally or in writing.

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
- ☐ ________ Photos
- ☐ 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 Client Date

______________________________ ______________________________
Signature of Witness Date

____
Name of Witness

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)*

Nursing Notes, Birth Records, Developmental screens, SLP and OT Assessments, Mental Health, Lab Reports, Out Pt Records, ER Visits, CAPC Records, DI Reports. Any other records 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

Northwest Central FASD Network

Phone	Address	City/Town	Province	Postal Code
780-674-4141	Box 5389	Westlock	AB	T7P 2P5

Purpose(s) of disclosure

Clinic for Assessment

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)*