Prairie Central FASD Clinical Services
Adult FASD Assessment Clinic

Thank you for your interest in the Prairie Central FASD Adult Assessment Clinic. The following package contains a referral information package, required consents, and an overview of what to expect during this process. Please note that all clients must have a designated representative to assist them through the referral and assessment process.

Who is the Clinic for?

The Adult FASD Clinic is for adults experiencing difficulties that are suspected to be a result of prenatal exposure to alcohol. These individuals may have difficulty with education, employment and independent living.

***Confirmation of prenatal alcohol exposure is required. The clinic coordinator will assist in gathering this information. ***

How does an individual access the clinic? Who can refer?

A referral is needed to access the clinic. The referring person can be a professional working with the client, including advocates from agencies that are associated with the Prairie Central FASD Association, health care and other agency professionals, or personal sources including family, adoptive parents, guardians or caregivers. Self-referrals can also be accepted as long as the individual is connected to supports and has a designated representative to assist them through the application and assessment process.

***The intent of the designated representative is to ensure the client has the best opportunity to apply the recommendations from the assessment. ***

What happens after my referral is submitted?

The client's referral information is reviewed by the Clinic Coordinator, who will gather additional client history, and conduct extensive record reviews to determine if the client fits the Canadian diagnostic criteria for FASD. Clients consent for the clinic to access records including birth, health and educational records, as well as other relevant documentation such as adoption, mental health and social service records. **It may take up to three months or longer** for these records to be received.

How is FASD Diagnosed?

This clinic uses **The Canadian Guideline for Fetal Alcohol Spectrum Disorder** (*Fetal alcohol spectrum disorder: a guideline for diagnosis across the lifespan* 2015).

FASD is diagnosed by considering evidence of a number of criteria, including the level of brain function in individuals exposed to alcohol during gestation. Not all individuals exposed to alcohol during gestation have an FASD. Not all referrals will go forward for assessment if the obtained documentation does not support the diagnostic criteria.

The Clinic Coordinator will set up a meeting with the client and their representative to review the outcome of the application and information gathering process and explore next steps for the client.

****Not all applications will proceed for a full assessment or diagnosis. ****

What happens in the assessment process?

The assessment team includes a Coordinator, Psychologist, Physician and auxiliary members. The team will work with the client, their representative, and any other support people that they would like to involve.

The assessment will consist of at least two sessions and more time may be required for further consultation.

Clients and/or their family members/caregivers will be interviewed by the Clinic Coordinator.

Clients will complete approximately 4 or more hours of testing with the Psychologist to look at their thinking skills.

The Physician will conduct a health screen and examine facial features that are sometimes seen with prenatal alcohol exposure.

How will the results of the assessment be provided?

Clients **may or may not** receive an FASD diagnosis, however the results of the assessment will be shared with the client and their representatives. Clients and their support people will have an opportunity to learn about their strengths and areas of difficulty, and recommendations will be provided that will include linkages to services and supports. The representative will help with the implementation of the recommendations.

Included in this package:

- Adult Assessment Clinic overview
- Required Consents
- Referral Package
- Alberta Health Services Consent (General Medical & Birth Records)

For additional information please contact

FASD Clinical Services in:

Clinic Coordinator: Amanda Lindholm
Phone: 587-386-0186
Email: a.lindholm@prairiecentralfasd.ca

Prairie Central FASD
Fetal Alcohol Spectrum Disorder

Prairie Central FASD Clinical Services
Consent for Assessment and Representation Form

Consent for Representation

I, _____ consent to have an assessment for Fetal Alcohol
Client Name
Spectrum Disorder (FASD). I grant permission for _____
Representative
to serve as my support person and representative throughout my involvement with the Adult FASD Assessment Clinic. This role includes serving as the primary contact person, arranging my appointments, receiving the final FASD Medical Report from the clinic and assisting me with assessments, recommendations and management plan.

Acknowledgement of Representation

I, _____ agree to serve as the representative for
Representative
_____ throughout the Adult FASD
Client Name
Assessment Clinic Process. I recognize that accepting the role of representative includes arranging the client's appointments, receiving the final FASD Medical Report from the clinic, supporting the client throughout the entire process and assisting them with recommendations and management plan.

_____ _____
Client's Signature Date

_____ _____
Representative's Signature Date

Prairie Central FASD Clinical Services

Consent to Obtain/Release Information

I,_____ (full legal name of client), birthdate _____(dd/mm/yy) hereby authorize the Prairie Central Fetal Alcohol Spectrum Disorder Association to OBTAIN/RELEASE confidential information verbally or in writing for the purpose of coordinating an assessment and diagnosis, developing a continuum of care recommendations, and to make appropriate referrals.

The diagnostic information collected will be entered into an anonymized dataform for research purposes.

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

Name and address of the individual/agency from/for whom information is to be obtained and/or released:

Clinic Coordinator, Prairie Central Fetal Alcohol Spectrum Disorder Association

FASD Clinical Services
4838 49 Street
Camrose, AB T4V 1N2

_____ _____
Signature of Client Date

_____ _____
Signature of Witness Date

Your information is collected under the authority of section 33(c) of the *Freedom of Information and Protection of Privacy Act*. If you have any questions about the collection and/or release of information, contact the Executive Director, Prairie Central FASD Association, Box 74 Killam, AB T0B 2L0 or at 780-385-3717.

FASD Clinical Services

Consent for Release of Information

Name: _____

Date of Birth: _____

Alberta Healthcare #: _____

As per the Province of Alberta Health Information Act (HIA), and the Freedom of Information and Protection of Privacy Act (FOIP) I, _____, hereby authorize the necessary Departments, Agencies, Services and Organizations to release any of my past and present reports and assessments as listed below, to Prairie Central FASD Clinical Services, Adult FASD Assessment Clinic Coordinator.

Please ensure boxes are checked appropriately

- [ ] Birth records, medical and hospital records (e.g. discharge summaries)
- [ ] Other medical assessments (e.g. Family Doctor, Occupational therapy, speech and language, vision, hearing assessments, etc)
- [ ] School records (student records, psycho-educational assessments, IPPs)
- [ ] Government of Alberta Child and Family Services records (adoptive and foster placements, child protection assessments, treatment summaries and parenting assessments)
- [ ] Government of _____ Child Protection and Adoption or Foster Services Records
- [ ] Mental Health & Addictions, and/or Psychiatry Records (intake &assessment reports, diagnostic & treatment summaries, consults & recommendation reports)
- [ ] Alberta Justice and Solicitor General Correctional Services (pre-sentence reports, psychological assessments, diagnostic and treatment summaries)
- [ ] Psychological and/or Neuropsychological assessments & reports
- [ ] Alberta Human Services; Alberta Works and/or Service Canada support services
- [ ] Community Health Services/Public Health records

I understand why I have been asked to disclose my individually identifying health information, and I am aware of the risks or benefits of consenting or refusing to consent to the disclosure of my individually identifying health information. I understand that I my revoke this consent in writing at any time.

This consent expires two years form date of signature. A photocopy or facsimile of this consent shall be as valid as the original.

_____

Client Signature Print Name Date

_____

Witness Signature Print Name Date

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)*

Newborn record, Notice of Live Birth, Antenatal record (risk assessment), Pre & Postnatal Records, Discharge Summary, Lab reports, Medical reports/consultations, emergency visits or hospitalizations, related information regarding Fetal Alcohol Spectrum Disorder or genetic disorders, speech/language/occupational/physical therapy assessments, psychological/psychiatric testing and consults, other reports (medical, functional or social)

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
Clinic Coordinator, Prairie Central FASD Clinical Services

Phone	Address	City/Town	Province	Postal Code

Purpose(s) of disclosure
To provide comprehensive medical history of care received by patient, as part of clinical assessment process.

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)*

o **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)
o **Nearest relative under Mental Health Act** - if access to health information is necessary to carry out obligations of the nearest relative
o **Agent** - appointed in an enacted personal directive according to the Personal Directives Act
o **Personal representative** - of a deceased patient, if the access to information relates to administration of the individual's estate
o **Power of attorney** - if access to health information relates to the powers and duties of the attorney
o **Written authorization** - any written authorization from the individual to act on the individual's behalf
o **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)*

Prairie Central FASD
Fetal Alcohol Spectrum Disorder

FASD Clinical Services
Referral Information

Date Received:

1. CLIENT INFORMATION – Please provide a copy of Picture Identification

Name of individual: _____ Male_____Female_____

Name at birth if different from above/other names used: _____

_____

Address: _____Postal Code: _____

Phone: _____ Cell Phone Number: _____

Health Care Number: _____ Date of Birth: _____

Hospital Where Born: _____ Address of Hospital: _____

Dependents: _____ Age of Dependents: _____

Primary Language Spoken at Home: 1. _____ 2. _____

Cultural Origin: *Caucasian* _____ *First Nations*_____ *Metis*_____*Other* _____

On Reserve: Yes No Treaty: Yes No If yes, Treaty #_____

2. REFERRAL INFORMATION -Attach a copy of the Guardianship Order (if applicable)

Name of Individual Making Referral: _____

Relationship to Individual: _____

Occupation/Agency: _____

Address: _____

Phone: _____ Email: _____

3.Birth Family Information

Biological Mother's Name: _____

Address: _____

Phone: _____ Email: _____

Biological Father's Name: _____

Address: _____

Phone: _____ Email: _____

4. SERVICES/SUPPORTS/AGENCY INVOLVEMENT

(a) **Is Child and Family Services currently involved?** Yes _____ No_____ Unknown _____

Name of Caseworker: _____ Agency: _____

Phone: _____ Fax: _____

Has Child and Family Services ever been involved (as a child or adult)? Yes _____ No _____

When? _____ Where? _____

(b) **Name of Family Doctor: _____ Clinic: _____**

City: _____

Phone: _____ Fax: _____

(c) **Please check all current supports being accessed and name of worker:**

AISH: _____ Contact: _____

PDD: _____ Contact: _____

Alberta Works: _____ Contact: _____

Mental Health: _____ Contact: _____

Addiction Services: _____ Contact: _____

FASD Outreach/PCAP: _____ Contact: _____

Public Guardian/Trustee: _____ Contact: _____

Probation/Parole: _____ Contact: _____

Cultural Supports (Elder/Native Friendship Centre): _____ Contact: _____

Other (please specify): _____

Contact: _____

(d) **School/Employment**

Is the client currently in school or a training program? Yes _____ No _____

Name of School or Training Program: _____ Grade: _____

Is the individual currently employed? Yes _____ No _____Part Time _____ Full Time _____

Name of Employer: _____

Name and location of last school attended _____

5. ASSESSMENT AND DIAGNOSIS

Why is an assessment being requested? (Please fill all that apply)

(a) What do you know about this person that leads you to believe he/she may have FASD?

_____

_____

_____

(b) Has there been confirmation of alcohol exposure during pregnancy? _____

(c) What is the source of confirmation of maternal alcohol exposure?

Birth Mother _____ Birth Father_____ Other Relative_____ File records_____

Other_____

(d) Contacts for confirmation of prenatal alcohol exposure (PAE):

Name and contact information (relationship)

_____

_____

PLEASE ATTACH COPIES OF PREVIOUS ASSESSMENTS

(e) Previous FASD Diagnosis Yes _____ No_____ Unknown_____

If yes, Name of Professional that compiled: _____ Address: _____

Diagnosis: _____ Date Assessment Completed: _____

(f) Have there been other assessments completed? (IE: Ed-Psych, Neuro-Psych, Functional)

Please List_____

_____

(g) Please check off all areas of concern:

Problems at home	Problems at school	Learning	Cognition
Hyperactivity	Fine Motor Skills	Gross Motor Skills	Academic
Impulsivity	Hearing/Vision	Behaviour	Speech
Work/School Readiness	Memory	Emotional	Language
Health/Lifestyle Concerns	Attention Problems	Social	Medical

Other concerns_____

(h) Is this assessment required for any other applications?

AISH_____ PDD_____ Public Guardian/Trustee_____ Court_____

(i) How urgent is the need for assessment and diagnostic services?

Very urgent _____ Not urgent _____

Please provide rationale: _____

(j) Please check all areas that apply to the client:

Housing issues: Past _____ Current _____

Describe: _____

Addiction Issues: Past _____ Current _____

Describe: _____

Legal Issues (Including past involvement): Past _____ Current _____

Describe: _____

Domestic Violence: Past _____ Current _____

Describe: _____

Mental Health: Past _____ Current _____

Describe: _____

Employment: Past _____ Current _____

Describe: _____

6. What are the strengths and interests of this person?

_____

_____

_____

7. Have you discussed this referral for assessment with the client?

_____

_____

Please add any additional information you think would be helpful:

_____

_____

_____

_____

_____

_____

I, _____, understand that sharing personal and confidential information with Prairie Central Adult FASD Clinic will be necessary to facilitate my application and request for an FASD assessment.

I understand why I have been asked to disclose identifying health information, and I am aware of the risks and/or benefits of consenting or refusing this consent.

I understand that this information will be forwarded to the diagnostic physician and/or assessment clinic only. I understand that the data may be entered anonymously for statistics keeping and research. I understand that I may revoke this consent in writing at any time.

This consent expires one year from the date of the signature. A photocopy or facsimile of this consent shall be valid as the original.

_____ _____

Signature of Client Date

_____ _____

Witness Date

_____ _____

Signature of Guardian (if applicable) Date

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Please send the completed package via email, fax, or mail as below:

FASD Clinical Services
Clinic Coordinator: Amanda Lindholm
Phone: 587-386-0186
Email: a.lindholm@prairiecentralfasd.ca
Fax: 587-386-0039
Mail: 4838 49 Street
Camrose, AB T4V 1N2