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. If there is a legal Guardian appointed, please attach a copy of the order.*

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. ***

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

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 or other agencies; or personal sources including family, adoptive parents, guardians or caregivers. Self-referrals can also be accepted if 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 the evidence of a number of criteria, including a comprehensive neurodevelopmental assessment of the 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 contact the referral source to review the outcome of the application and to discuss the information gathering process as well as to explore next steps for the client.

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. 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 for the neurodevelopmental assessment. The Physician will conduct a health screen and examine for 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:

- Required Consents
- Referral Package
- Alberta Health Services Consent

For additional information please contact

FASD Clinical Services:
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 support 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 support plans.

_____ _____
Client or Guardian 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
#205 4917 50 Ave.
Camrose, AB T4V 0S2

_____ _____
Signature of Client or Guardian 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, #205 4917 50Ave, AB T4V 0S2 or at 780-385-3717.

Prairie Central 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 or Guardian Signature | Print Name | Date

_____

Witness Signature | Print Name | 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.

Birth records, pre & postnatal records, discharge summaries, emergency and hospitilization records, lab reports, other medical reports/consultations, Psychological/Psychiatric admissions testing and consults, genetic disorders

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

Name of Individual/Organization		Phone	
Prairie Central FASD Clinical Services		(587) 386-0186	
Address	**City/Town**	**Province**	**Postal Code**
205, 4917 50 AVE	Camrose	AB	T4V0S2

Section D: What is the purpose for disclosure?

Please provide the reason why you want to disclose the health information *(required)*.

For continuance of care and a comprehnsive FASD medical assessment completed by the FASD assessment teams registered Psychologist and Physician

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.

I, _____, am

(insert representative name)

- ☐ the **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.
- ☐ the **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.
- ☐ the patient/client's **agent** named in an activated Personal Directive under the *Personal Directives Act* exercising my authority set out in the Personal Directive.
- ☐ the **personal representative** of a deceased patient/client appointed by the patient/client's will or by the Court, administering the patient/client's estate.
- ☐ the patient's **named attorney** in a Power of Attorney currently in effect exercising my powers and duties conferred by the Power of Attorney.
- ☐ the patient/client's **nearest relative** selected in accordance with the *Mental Health Act* carrying out my obligations as the nearest relative.
- ☐ the 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.
- ☐ a **person with written authorization** from the patient/client to act on their behalf.

Section F: 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	**Phone**	**Email**
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.

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Prairie Central FASD Clinical Services
Referral Information

Date Received:

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

Name of individual: _____ M_____F_____Other_____

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

_____

Address: _____Postal Code: _____

Cell Phone Number: _____

Health Care Number: _____ Date of Birth: _____

Hospital Where Born: _____ City: _____

Dependents: _____ Age of Dependents: _____

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

Ethnic group identified with: *Caucasian* _____ *Indigenous*_____ *Metis*_____*Other* _____

Primary residence on Reserve: Yes_____ No_____

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: _____

Have you discussed the assessment process with the client? Yes No

Was this referral form completed with the client? _____

3. Birth Family Information **** Biological parents will not be contacted by the clinic without client consent****

Biological Mother's Name: _____

Address: _____Phone: _____

Biological Father's Name: _____

Address: _____Phone: _____

4. ASSESSMENT AND DIAGNOSISTIC INFORMATION

(a) Reason(s) for Referral

___ Behavioral Concerns _____ Confirmed Prenatal Exposure

___ Learning Difficulties _____ Social Skills Difficulties

___ Difficulties with the Law _____ Self -regulation Difficulties (sleep, eating, sensory)

___ Developmental Delays _____ Reassessment

___ Adaptive Living Concerns _____ Establish Eligibility for Supports (financial or support programs)

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

What is the source of confirmation of maternal alcohol exposure?

Birth Mother _____ Birth Father_____ Other Relative_____

Other_____

(c) Is there confirmation of other substances exposure during pregnancy? Please Specify:

_____ Stimulants (Cocaine, Crack, Ecstasy, Meth, ect.):_____

_____ Opiates (Fentanyl, Heroin, Oxycodone, Methadone, ect):_____

_____ Cigarettes _____Marijuana _____ Solvents ____ Hallucinogens

_____ Prescription Medications (Anticonvulsants, Antipsychotics, Pain Killers, ect): _____

_____

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

Name and contact information (relationship)

_____

(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)

Please List_____

_____

Please attach copies of reports for any previously completed assessments

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

Very urgent _____ Not urgent _____

Please provide rationale: _____

(h) 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: _____

Family Violence: Past _____ Current _____

Describe: _____

Mental Health Concerns: Past _____ Current _____

Describe: _____

Employment Issues: Past _____ Current _____

Describe: _____

Financial Concerns (income and/or money management): Past _____ Current _____

Describe: _____

Health Concerns (Chronic or untreated): Past _____ Current _____

Describe: _____

Social Skills Concerns: Past _____ Current _____

Describe: _____

Adaptive Living Skills: Past _____ Current _____

Describe: _____

5. SERVICES/SUPPORTS/AGENCY INVOLVEMENT

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

Name of Caseworker: _____ Office: _____

Phone: _____

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: _____

(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**

Name and location of last school attended: _____

Last grade completed: _____

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

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

Name of Employer: _____

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

_____

_____

Please add any additional information you think would be helpful:

_____

_____

_____

_____

_____

_____

I, _____, understand that sharing personal and confidential information with Prairie Central FASD Clinical Services 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, psychologist and 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 two years 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: 205, 4917 50 Avenue
Camrose, AB T4V 0S2