Referral for an FASD Assessment (Age 7+)

INTAKE INFORMATION

PATIENT INFORMATION

Legal Name: _____

All Former Names: _____

Birth Date: Day _____ Month _____ Year _____

Gender: _____

Personal health care #: _____

Cultural Origin: ☐ Caucasian ☐ Indigenous (First Nations) ☐ Metis ☐ Inuit ☐ Other _____

Treaty Status # (if applicable): _____

Immigrant/Refugee ☐Yes ☐No. If yes, how many years in Canada: _____

Primary language spoken in the home: _____

Address: _____

Phone: _____

Email: _____

Are there any accessibility/mobility concerns? ☐Yes ☐No If yes, please specify: _____

Transportation: ☐ Yes, I have access to transportation ☐ No, I will need assistance with transportation

LEGAL GUARDIAN INFORMATION (if applicable)

☐ Biological Parent(s) ☐ Adoptive Parent(s) ☐ Children's Services ☐ Other: _____

If Children's Services: ☐ Permanent Order ☐ Temporary Order ☐ Voluntary Placement Agreement ☐Kinship

Name: _____

Phone: _____

Email: _____

Name: _____

Phone: _____

Email: _____

Proof of Guardianship is Attached: ☐Yes ☐No ☐Not applicable

If applicable, please provide proof of guardianship. All guardians will be required to sign consent forms.

DESIGNATED REPRESENTATIVE (MAIN CONTACT AND SUPPORT)

To ensure that individuals are supported and enable them to complete the assessment process, we require them to have a designated representative to assist them through the application and assessment process.

***Please Complete Designated Representative Form at end of referral.**

Name: _____

Relationship to Individual: _____

Phone: _____

Email: _____

REFERRAL INFORMATION

Name of Person Referring: _____

Relationship to Individual: _____

Phone: _____

Email: _____

REASON(S) FOR REFERRAL

☐ Prenatal Alcohol Exposure known	☐ Learning/Education
☐ Re-assessment	☐ Employment
☐ To determine eligibility for supports (AISH, PDD, and OPGT)	☐ Relationships
☐ Legal	☐ Mental Health
☐ Day-to-Day living	☐ Physical Health
	☐ Other:

FUNDING

Any sources of funding available to cover the cost of assessment?

If the individual has an open file with Children's Services, then they are requested to cover the cost of assessment.

☐Children's Services ☐ Supports for Permanency ☐ Jordan's Principle ☐ Fee for Service ☐ No source of funding

☐ Other: _____

CURRENT SITUATION

WHAT SERVICES/SUPPORTS ARE CURRENTLY BEING ACCESSED?

*Please provide name of worker or program, if applicable.

☐Referral sent to a Pediatric Specialty Clinic: ☐ Yes ☐ No. If yes, what clinic? _____

☐Medical Doctor or Clinic: _____

☐Psychiatrist: _____

☐Income Support ☐ AISH ☐ Band Social Assistance: _____

☐Public Guardian: _____

☐Trustee: _____

☐FSCD/PDD: _____

☐Supports for Permanency (SFP): _____

☐Children's Services: _____

☐PT: _____

☐SLP: _____

☐OT: _____

☐School Supports: _____

☐Mental Health Supports: _____

☐Addictions Services: _____

☐PCAP ☐FASD Outreach: _____

☐Probation ☐Parole: _____

☐Cultural Services: _____

☐Housing: _____

☐Other: _____

☐Other: _____

INDIVIDUALS GOALS (required for clinic and recommendations)

Self- Identified:	Support/Caregiver Identified:
_____	_____
_____	_____

INDIVIDUALS STRENGTHS (required for clinic and recommendations)

Self- Identified:	Support/Caregiver Identified:
_____	_____
_____	_____

RELATIONSHIPS, HOUSING, INCOME, EMPLOYMENT/VOLUNTEERING, AND CULTURAL/SPIRITUAL PRACTICES

_____

_____

_____

_____

CURRENT EDUCATION

Attending school? ☐ Yes ☐ No If yes, what grade level? _____

Name of School: _____

Alternative programming in place. ☐ Yes ☐ No

SOCIAL HISTORY

EDUCATION AND EMPLOYMENT HISTORY

_____

_____

_____

GUARDIANSHIP HISTORY

Was the individual adopted? ☐ Yes ☐ No

If yes, at what age? _____

How many caregivers have been involved throughout their life? _____

Who were the primary caregivers throughout the individual's life? _____

_____

CHILDREN'S SERVICES

Is there current Children's Services Involvement? ☐ Yes ☐ No

Has there been Child and Family Services involvement in the past? ☐ Yes ☐ No

Age of first involvement: _____

If yes to past services for a <u>closed</u> file, please provide two pieces of the *individuals* ID to request records from Children's Services. ☐ ID Attached

HAS THE INDIVIDUAL EXPERIENCED *OR* WITNESSED ANY OF THE FOLLOWING:

☐ Multiple caregivers	☐ Physical abuse	☐ Emotional abuse
☐ High conflict custody/access situation	☐ Physical neglect	☐ Emotional neglect
☐ Abandonment	☐ Sexual abuse	☐ Significant losses
☐ Family violence	☐ Sexualized behaviors	☐ Other traumatic events

_____

_____

_____

LEGAL/JUSTICE INVOLVEMENT

☐Past ☐Present ☐Not applicable

☐Family Court ☐Criminal Court ☐Other: _____

_____

_____

RCMP/POLICE INTERACTIONS

☐Past ☐Present ☐Not applicable

_____

_____

GANG INVOLVEMENT

☐Past ☐Present ☐Not applicable

_____

MEDICAL INFORMATION

DIAGNOSES

				If yes, please state who/where diagnosed the condition.
Depression	☐Yes	☐No	☐Suspected	_____
Anxiety	☐Yes	☐No	☐Suspected	_____
Obsessive Compulsive Disorder	☐Yes	☐No	☐Suspected	_____
ADHD	☐Yes	☐No	☐Suspected	_____
Oppositional Defiant Disorder	☐Yes	☐No	☐Suspected	_____
Sensory Concerns	☐Yes	☐No	☐Suspected	_____
Autism	☐Yes	☐No	☐Suspected	_____
Schizophrenia	☐Yes	☐No	☐Suspected	_____
Personality Disorder	☐Yes	☐No	☐Suspected	_____
Other: _____	☐Yes	☐No	☐Suspected	_____
Other: _____	☐Yes	☐No	☐Suspected	_____
Other: _____	☐Yes	☐No	☐Suspected	_____

MEDICATIONS

Please list any medications the individual is currently taking:

_____

_____

HOSPITALIZATIONS AND SURGERIES

☐Yes ☐No. If yes, please list hospitals attended.

_____

_____

ALLERGIES

☐Yes ☐No. If yes, please provide details.

_____

SLEEP CONCERNS

Approximately how many hours of sleep a night? _____

☐Frequent nightmares ☐Difficulty falling asleep ☐Difficulty staying asleep ☐other (please describe)

_____

_____

DEVELOPMENTAL CONCERNS

Has the individual had difficulty with any of the following?

☐Gross motor skills (use of large muscles for balance and coordination – ex. running, biking, climbing, etc.)

☐Fine motor skills (movements with detailed small muscles in hands/wrists – ex. writing, drawing and using scissors)

☐Expressive Language skills (trouble expressing thoughts, difficulty describing things to people, etc.)

☐Receptive Language skills (difficulty understanding new ideas, or what people are saying, etc.)

☐Social skills (getting along with other people, taking turns, asking for help, etc.)

☐Growth (any concerns with growth as a child)

Please describe current or past developmental concerns:

_____

_____

BEHAVIOURAL CONCERNS

Has the individual had difficulty with any of the following?

☐Inattention (easily distracted, difficulty sustaining attention, etc.)

☐Hyperactivity (fidgety, difficulty playing or engaging in leisure activities quietly, "on the go", etc.)

☐Impulsivity (often has difficulty waiting turn, often interrupts or intrudes on others, etc.)

☐Oppositional Behaviours (often loses temper, often blames other for their mistakes, defiant, etc.)

☐Inappropriate Conduct (bullying, threats, inappropriate physical/emotional/sexual activities, etc.)

☐Emotional Functioning (excessive worrying or anxiety, fatigue/tired on a regular basis, sleep disturbances, etc.)

☐History of violence towards others.

☐History of sexual violence towards others.

Please describe current or past behavioural concerns:

_____

_____

MENTAL HEALTH CONCERNS

Self Harm ☐Past ☐Present ☐Not applicable **Suicidal thoughts/behaviours** ☐Past ☐Present ☐Not applicable

_____

_____

SUBSTANCE USE CONCERNS

☐Past ☐Present ☐Not applicable

History of violence while under the influence of substances: ☐Past ☐Present ☐Not applicable

_____

REVIEW OF MEDICAL SYSTEMS

ENT (EAR NOSE AND THROAT)

Ex. hearing loss, abnormal anatomy – cleft lip/palate, etc.

Hearing Exam: ☐Yes ☐No If yes, date of last exam: _____

Any concerns? ☐Yes ☐No. If yes, please provide details.

OPHTHALMOLOGY

Ex. strabismus, etc.

Glasses or Contacts: ☐Yes ☐No

Eye Surgery: ☐Yes ☐No

Date of last eye exam: _____

Any concerns? ☐Yes ☐No. If yes, please provide details.

Other information:

CARDIOVASCULAR CONDITIONS

Ex. abnormal structures, heart attack, heart failure, etc.

Any concerns? ☐Yes ☐No. If yes, please provide details.

RESPIRATORY CONDITIONS

Ex. asthma, COPD, chronic bronchitis, etc.

Any concerns? ☐Yes ☐No. If yes, please provide details.

ENDOCRINOLOGICAL CONDITIONS

Ex. diabetes, thyroid concerns, osteoporosis, etc.

Any concerns? ☐Yes ☐No. If yes, please provide details.

GASTROINTESTINAL

Ex. malabsorption, encopresis, enuresis, bowel accidents, bed wetting, etc.

Any concerns? ☐Yes ☐No. If yes, please provide details.

GENITOURINARY

Ex. dysplastic kidneys, ureteral duplications, hypospadias, undescended testes, etc.

Any concerns? ☐Yes ☐No. If yes, please provide details.

MUSCULOSKELETAL

Ex. joint abnormalities, spina bifida, scoliosis, etc.

Any concerns? ☐Yes ☐No. If yes, please provide details.

NEUROLOGICAL

Ex. structural brain abnormalities (past MRI or CT scan), seizures, concussions, etc.

Concussion(s): ☐Yes ☐No.

Seizure(s): ☐Yes ☐No.

MRI: ☐Yes ☐No.

CT: ☐Yes ☐No.

If yes to any of the above, please provide details such as hospital or facility attended.

Any concerns? ☐Yes ☐No. If yes, please provide details.

Other information:

RECORDS

ASSESSMENTS

	Name of Clinician/Clinic	Date(s) of Assessment	Report Attached &/or Currently Involved
☐ Prior FASD clinic			☐Report Attached ☐Currently involved
☐ Child Development Clinic			☐Report Attached ☐Currently involved
☐Genetics			☐Report Attached ☐Currently involved
☐ Occupational Therapist			☐Report Attached ☐Currently involved
☐Physiotherapist			☐Report Attached ☐Currently involved
☐Psychologist			☐Report Attached ☐Currently involved

☐Pediatrician			☐Report Attached ☐Currently involved
☐Psychiatry/ Mental Health			☐Report Attached ☐Currently involved
☐Speech Language Pathologist			☐Report Attached ☐Currently involved
☐Medical Doctor/Clinic			☐Report Attached ☐Currently involved
☐Other			☐Report Attached ☐Currently involved

RECORDS TO BE REQUESTED

Please list all relevant hospitals, clinics, professionals, and institutions to request records for further information and documentation of all diagnoses, assessments, relevant school records, etc.

Name of place to be requested from	*Fax number for record requests*

PRE AND POSTNATAL INFORMATION

BIRTH RECORD INFORMATION

Birth Hospital: _____

Released into the care of: _____

PATERNAL HISTORY (Biological Father)

Name: _____

DOB/Present Age: _____

Cultural Origin: ☐ Caucasian ☐ Indigenous (First Nations) ☐ Metis ☐ Inuit ☐ Other _____

Mental Health: _____

Diagnosis'/medical conditions: _____

Education/Employment at time of pregnancy: _____

Education/Employment now: _____

MATERNAL HISTORY (Biological Mother)

Name: _____

DOB/Present Age: _____

Cultural Origin: ☐ Caucasian ☐ Indigenous (First Nations) ☐ Metis ☐ Inuit ☐ Other _____

Mental Health: _____

Diagnosis'/medical conditions: _____

Education/Employment at time of pregnancy: _____

Education/Employment now: _____

Is the biological mother aware of this referral? ☐ Yes ☐ No

Is it possible to speak to the biological mother? ☐ Yes ☐No ☐Unknown

Contact will not be made without prior discussion with the individual/guardian.

Phone: _____

Email: _____

Any additional information regarding contacting biological mother: _____

PRENATAL HISTORY OF BIOLOGICAL MOTHER

Number of previous pregnancies: _____

Children with diagnosis of FASD: _____

SOCIAL SITUATION OF BIOLOGICAL MOTHER AT TIME OF PREGNANCY

Ex. housing, income, nutrition, supports, risk factors, etc.

_____

_____

_____

_____

MEDICAL HISTORY OF BIOLOGICAL MOTHER DURING PREGNANCY

When pregnancy discovered (how far along): _____

Maternal age at delivery: _____

Additional information: ex. Prenatal care, hospital admissions, diabetes, hypertension, infections, medications etc.

_____

_____

_____

_____

PRENATAL ALCOHOL EXPOSURE (PAE) INFORMATION

SOURCE OF PAE INFORMATION

Who is source of this information (name): _____

Phone: _____

Email: _____

Would you prefer a phone interview to discuss this? ☐Yes ☐No, if no please add information below.

Would you prefer an in-person interview (if possible) to discuss this?

☐Yes ☐No, if no please add information below.

Relationship to the individual: _____

Relationship to the biological mother (if not biological mother): _____

Witnessed alcohol use during pregnancy personally? ☐Yes ☐No

Was disclosed by biological mother? ☐Yes ☐No

Disclosed in other records? ☐Yes ☐No

PRENATAL ALCOHOL EXPOSURE (PAE)

Confirmation of prenatal alcohol exposure is required prior to assessment and the clinic can assist with gathering the details of this information.

Before Pregnancy: ☐ Yes ☐ No ☐ Suspected ☐ Unknown

How many drinks on any one occasion? ☐0 ☐1 ☐2 ☐3 ☐4 ☐5+

Number of drinking occasions per week? ☐unknown ☐0 ☐1 ☐2 ☐3 ☐4 ☐5+

Number of drinking occasions per month? ☐unknown ☐0 ☐1 ☐2 ☐3 ☐4 ☐5+

During Pregnancy: ☐ Yes ☐ No ☐ Suspected ☐ Unknown

How many drinks on any one occasion? ☐0 ☐1 ☐2 ☐3 ☐4 ☐5+

How many occasions during pregnancy? ☐unknown ☐0 ☐1 ☐2 ☐3 ☐4 ☐5+

Trimester(s) in which alcohol was consumed ☐1st ☐2nd ☐ 3rd ☐ None.

Any additional alcohol use information during pregnancy (ex. alcohol preference, significant events, etc.):

_____

Continued next page.

_____
_____
_____
_____
_____
_____
_____

OTHER EXPOSURES DURING THIS PREGNANCY

Tobacco	☐Yes	☐No	☐Suspected	☐Unknown
Cannabis	☐Yes	☐No	☐Suspected	☐Unknown
Cocaine	☐Yes	☐No	☐Suspected	☐Unknown
Methamphetamine	☐Yes	☐No	☐Suspected	☐Unknown
Solvents	☐Yes	☐No	☐Suspected	☐Unknown
Prescription Drugs	☐Yes	☐No	☐Suspected	☐Unknown
Mercury	☐Yes	☐No	☐Suspected	☐ Unknown

Additional information regarding substance use during pregnancy:

_____
_____
_____
_____

Please contact the Central Alberta FASD Network at 403-342-7499 if you have any questions or concerns regarding this referral form or the process of assessment and diagnosis.

What is FASD

Fetal Alcohol Spectrum Disorder (FASD) is a diagnostic term used to describe impacts on the brain and body of individuals prenatally exposed to alcohol. FASD is a lifelong disability. Individuals with FASD will experience some degree of challenge in their daily living and need support with motor skills, physical health, learning, memory, attention, communication, emotional regulation, and social skills to reach their full potential. Each individual with FASD is unique and has areas of both strengths and challenges

CONSENT FORMS

CENTRAL ALBERTA FASD CLINIC CONSENT FORM

- **All legal guardians must sign all consent forms.**
- **Please provide proof of guardianship, if applicable.**
- In Section 2 please provide any other supports or agencies you would like information to be shared with in order to provide information and support (such as housing agencies, schools, etc.).

CONSENT FOR AND ACKNOWLEDGEMENT OF REPRESENTATION

- Primary contact and support for the individual. To ensure that individuals are supported to enable them to complete the assessment process, we require them to have a designated representative to assist them through the application and assessment process.
- Assists with arranging and attending appointments if necessary, assisting with questionnaires, and applying clinic recommendations.

GUARDIAN CONSENT FORM FOR CLIENT SUPPORT

- If the individual is a minor (age 14+) or a represented adult, then we request consent to speak with them to provide information and support.

DECLARATION OF GUARDIANSHIP AUTHORITY AND CONSENT FOR ASSESSMENT

- If client is under 18 the form is to be signed by parent/guardian with decision-making abilities.
- If client is over 18 and a represented adult the form is to be signed by their guardian.

CENTRAL ALBERTA FASD
FETAL ALCOHOL SPECTRUM DISORDER CLINIC

#206, 33 Mckenzie Crescent,
Red Deer County, Alberta, T4S 2H4
Phone: 403-342-7499
Fax: 403-358-6098
Website: www.centralfasd.org

Central Alberta FASD Clinic Consent Form

SECTION 1: Consent for the Collection/Receipt of Personal or Confidential Information

I, _____ (Client/Legal Guardian(s)), authorize and give permission to the Central Alberta FASD Network to receive documents/information from the following:

Yes	No		Yes	No	
❒	❒	Birth Records, Notice of live birth	❒	❒	School Records
❒	❒	Health Records	❒	❒	Children's Services/Post Adoption
❒	❒	Mental Health Records	❒	❒	Past assessments
❒	❒	Addiction Treatment Records	❒	❒	Correctional Services of Canada
			❒	❒	Alberta Justice and Solicitor General Correctional Services
❒	❒	Other: _____			

Purpose of the Information:

This information will be used to assist the Assessment and Diagnostic Clinic team to determine eligibility for the assessment process, a diagnosis, develop recommendations, and make referrals. Your data will be reported to the Provincial FASD Networks secure electronic database into an *anonymized* data form for research purposes.

SECTION 2: Consent for the Request/Release of Personal or Confidential Information

In addition, information may be requested/released to the following for the purpose of determining eligibility for supports and services, providing suitable referrals, assisting with connections and transitions, providing documents and information for diagnosis and assessment as well as case management.

This may include any support agencies or people (i.e., school, doctor's office, mental health, friends/ family, etc.).

Yes	No		Yes	No	
❒	❒	Alberta Health Services	❒	❒	_____
❒	❒	Government of Alberta	❒	❒	_____
❒	❒	Jordan's Principle	❒	❒	_____
❒	❒	First Nations Health Consortium	❒	❒	_____
❒	❒	First Nations Community Health Centres	❒	❒	_____

I understand why I have been asked to disclose this information and I am aware of the risks or benefits of consenting or refusing to consent to the disclosure of this information. This consent may be withdrawn, by written notice, from the client/guardian at any time. A photocopy or facsimile of this form shall be deemed valid as an original.

Client's Name: _____

Client's Former Names: _____

Client's PHC#: _____ **Client's DOB (DD/MM/YYYY):** _____

_____ _____ _____
Signature of Client/Legal Guardian Print Name Date

_____ _____ _____
Signature of additional Legal Guardian (if applicable) Print Name Date

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FETAL ALCOHOL SPECTRUM DISORDER CLINIC

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Consent for and Acknowledgement of Representation

Consent for Representation

I, _____(Client/Legal Guardian) grant permission for _____(Designated Representative) to serve as the support person and representative throughout the time of involvement with the Central Alberta FASD Clinic.

Acknowledgement of Representation

I, _____(Designated Representative) agree to serve as the representative for _____(Client) throughout the Central Alberta FASD Clinic process.

I recognize that accepting the role of representative includes, but is not limited to, the following:

- Main contact as the individual completes assessment
- confirming attendance to appointments
- arranging the client's transportation
- attending appointments if necessary
- assisting with questionnaires
- support with recommendations
- contact for follow up

This consent may be withdrawn, by written notice, from the client/guardian at any time. A photocopy or facsimile of this form shall be deemed valid as an original.

_____	_____	_____
Signature of Client/Legal Guardian	Print Name	Date
_____	_____	_____
Signature of additional Legal Guardian	Print Name	Date
_____	_____	_____
Signature of Designated Representative	Print Name	Date

CENTRAL ALBERTA FASD
FETAL ALCOHOL SPECTRUM DISORDER CLINIC

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Guardian Consent Form for Client Support (Age 14+)

I, _____(Legal Guardian(s))

consent to have the Central Alberta FASD Network/Clinic contact

_____(dependent or represented adult) for the purpose of

providing information and support.

Dependent or Represented Adult's Contact Information

Name: _____
Phone: _____ Email: _____
Other method of contact such as Facebook: _____

Parent/Guardian's Emergency Contact Information

Name: _____
Relationship: _____
Phone: _____ Email: _____

Parent/Guardian's Emergency Contact Information (if there is an additional Parent/Guardian)

Name: _____
Relationship: _____
Phone: _____ Email: _____

If available, please provide proof of guardianship. All guardians will be required to sign consents.

This consent may be withdrawn, by written notice, from the guardian at any time. A photocopy or facsimile of this form shall be deemed valid as an original.

_____	_____	_____
Signature of Legal Guardian	Print Name	Date
_____	_____	_____
Signature of additional Legal Guardian	Print Name	Date

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Declaration of Guardianship Authority and Consent for Assessment

Client Under 18

If this client is under the age of 18 years, the parent/guardian that has parental decision-making abilities must give consent. If this is shard between two parents both parents must give consent for the assessment to take place.

Client Over 18 – Represented Adult

If this client is over the age of 18 years old and a represented adult, then the guardian must give consent for the assessment to take place.

Client Over 18 – Client with no guardian

Do not need to complete this form.

I, _____(Legal Guardian(s)) affirm as Legal Guardian(s) to have the authority to refer the individual for an FASD assessment and confirm all guardians are aware of this referral and have approved of the process.

_____	_____	_____
Signature of Legal Guardian	Print Name	Date
_____	_____	_____
Signature of additional Legal Guardian	Print Name	Date