Alberta Health Services

Glenrose Rehabilitation Hospital

Adult FASD Assessment Clinic

Fetal Alcohol Spectrum Disorders (FASD) is a term that includes all of the diagnoses/difficulties that individuals may have if they were exposed to alcohol prenatally (in the womb). These difficulties may involve problems with thinking, behavior, and emotional functioning.

As one of Canada's premier rehabilitation facilities, the Glenrose Rehabilitation Hospital offers specialized inpatient and outpatient programs for children and adults. Through the special skills of our physicians and staff, it is a place where patients and their families meet the challenges of disability and seek to improve their physical, mental, and spiritual health. Established in 1964, the Glenrose continues as a leader in geriatric and rehabilitation research, technology, education and rehabilitation programs for residents of Northern and Central Alberta and beyond.

The Adult FASD Assessment Clinic is funded by the Edmonton Fetal Alcohol Network Society (EFAN) and is administered through Alberta Health Services.

Who is the Clinic for?

The Adult FASD Assessment Clinic is for adults from the Edmonton Zone who are experiencing **significant** difficulties suspected to be the result of prenatal alcohol exposure. The problems the individual is experiencing are **not minor** in nature or the result of other problems such as alcohol and drug use or untreated mental illness although these problems may co-exist with an FASD diagnosis. These individuals may have difficulty with education, employment, and independent living.

*Any previous assessments should be considered as the individual may be able to use those assessments to access supports and funding such as AISH and may not require an FASD assessment.

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

A referral is needed and wait times will vary. When considering a referral, every effort should be made to address potential causes for the individual's challenges such as treatment for addiction and mental health, treatment for ADHD (if previously diagnosed), and accessing supports and services to help the individual achieve stability. Any assessments that were completed should be included with the referral.

Service providers from an agency or service associated with the Edmonton Fetal Alcohol Network Society (EFAN) and health care and other professionals can refer their clients for an assessment. The individual will require a Representative to assist throughout the assessment process. The Representative will be the primary contact and must be able to support their clients throughout the assessment process and be able to provide follow-up.

* The purpose of the Representative is to ensure the client is provided the best opportunity to apply the recommendations resulting from the assessment to their life.

Assessment Model: **The Canadian Guideline for Fetal Alcohol Spectrum Disorder diagnosis are used in this Clinic (*Fetal alcohol spectrum disorder: a guideline for diagnosis across the lifespan, 2015*)**

Who is involved?

The assessment team includes a Coordinator, a Neuropsychologist, a Psychometrist, a Registered Nurse, a Speech-language Pathologist; a Psychiatrist; and a Social Worker. During the assessment process the team will work with clients, their Representative, and other support people such as family members, and any professionals or service providers they may be working with.

What happens before an appointment?

Confirmation of prenatal alcohol exposure is needed before the assessment can take place. The clinic coordinator can assist with this.

Birth, health, education records as well as other relevant documents such as adoption, mental health, and social service records are required. Consent will need to be provided by clients for these records to be obtained.

When all of the records and required documentation are received, the Representative will be contacted to schedule an appointment.

What happens in the assessment process?

The assessment will consist of at least two sessions. More time may be required for consultation with a physician or other health care professionals before a diagnosis can be made.

Clients, their family members or caregivers, and their Representatives will be interviewed and asked to fill out some questionnaires. Clients will complete about six hours of testing to look at their thinking skills. The assessment will also include a brief health screen, and the nurse will take pictures to look at facial features that are sometimes seen in individuals with prenatal alcohol exposure. The clinic will consult with other specialists as needed to consider past or current health concerns that could impact the assessment.

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 them, their Representatives, their physician, and anyone else they choose to include. Clients (and their support people) will have an opportunity to learn about their strengths and areas of difficulty. A management plan to address their current needs will be developed and will include linkage to services and supports. The Representative will help with the implementation of the management plan.

For additional information contact:

Ph: **780-735-6166**
Fax: **780-413-4979**

Address:
Adult FASD Assessment Clinic
Glenrose Rehabilitation Hospital
10230 – 111 Ave
Edmonton, AB T5G 0B7

www.albertahealthservices.ca
www.edmontonfetalalcoholnetwork.org
www.fasd.alberta.ca

Intake forms can be found on the EFAN website under Supports and Services.

Intake Package
Referral Form

To: Attention: **Coordinator, Adult FASD Assessment Clinic**
FAX: **780-413-4979**

From: Name: _____

Agency: _____

Program: _____

Phone #: _____ Cell#: _____ FAX#: _____

Address: _____

_____

_____ Postal Code _____

Re: Referral to the GRH, Adult FASD Assessment Clinic

Please accept this referral for the following client:

Client: _____

DOB: _____ Age: _____

Alberta Health Care Insurance#: _____

Phone: Home _____ Cell: _____

Address: _____

_____

_____ Postal Code _____

If your client is Indigenous please specify: ☐ Yes ☐ No

First Nations – Treaty Status _____ First Nations – Non Treaty Status _____
Metis _____ Inuit _____

Referral letter attached _____ or Rationale provided below for the referral _____

The following are attached:

- ☐ Referral Letter or Rationale Provided
- ☐ Client Information Checklist
- ☐ Consent for Representation Form
- ☐ Consent for Release of Information
- ☐ AHS Consent to Disclose Health Information
- ☐ Other

Signature: _____ Date: _____

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Tel: 780-735-6167
Fax: 780-413-4979
www.albertahealthservices.ca

Representation Form

Consent for Representation

I, _____ consent to have an assessment for Fetal Alcohol Spectrum
Client Name

Disorder (FASD). I grant permission for my _____
Representative

from _____ at _____ to serve as my
Agency Name *Phone Number*

Representative and support person throughout my involvement with the Adult FASD Assessment Clinic. This role includes serving as the primary contact person, arranging my appointments, and assisting me with the management plan.

_____ _____
Client's Signature Date

Acknowledgement of Representation

I, _____ agree to serve as the
Representative

Representative for _____ throughout the Adult
Client Name

FASD Assessment Clinic process. I recognize that accepting the role of Representative includes the following responsibilities: arranging my client's appointments, supporting my client throughout the assessment process, and assisting my client with their management plan.

_____ _____
Representative's Signature Date

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Tel: 780-735-6167
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Client Information Checklist

(Please read and check the boxes)

I, _____, understand that by agreeing to participate in
Client Name
a Fetal Alcohol Spectrum Disorder (FASD) assessment:

- ☐ The FASD assessment team will seek confirmation that I was exposed to alcohol prenatally (in the womb).
- ☐ I will be involved in the assessment process, which may require three or more appointments.
- ☐ My medical, school, legal, and mental health records will be reviewed by the Adult FASD Assessment team.
- ☐ I may have to see another health care provider before I receive a diagnosis.
- ☐ I may not receive an FASD diagnosis.
- ☐ I will be provided with the opportunity to learn about my strengths and areas of difficulty.
- ☐ I will receive a management plan that will help me access the appropriate services in order to address my needs.

_____ _____

Client's Signature Date

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Edmonton, AB T5G 0B7

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Consent for Release of Information

Name: _____

Date of Birth: _____

Alberta Health Care #: _____

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 the Glenrose Rehabilitation Hospital, Adult Fetal Alcohol Spectrum Disorder (FASD) Assessment Clinic Coordinator.

Name

- ☒ 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, & IEPs)
- ☒ 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 Records (intake & assessment reports, diagnostic & treatment summaries) and Psychiatry (consults, recommendations and treatment summaries).
- ☒ Alberta Justice and Solicitor General Correctional Services (pre-sentence reports, medical, mental health, & psychological assessments, diagnostic and treatment summaries).
- ☒ Correctional Service of Canada (pre-sentence and Community Investigation reports, medical, mental health & psychological assessments, diagnostic and treatment summaries).
- ☒ Psychological and/or Neuropsychological assessments & reports

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 may revoke this consent in writing at any time.

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

_____

Signature Print Name Date

_____

Witness Print Name Date

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

Alberta Health Services

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 of this form, together with any records 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)*

Medical, functional, and social information needed *to allow the* ***Representative*** *to provide assistance through the pre, mid, and post Adult FASD Assessment Clinical process. This includes attendance at the "Debriefing/Management Planning" Conference.* **(GRH Adult FASD Assessment Clinic is releasing information to the Representative for their participation in the client's assessment process)**

Identify below where records exist

Health service provider, hospital, clinic program	City/Town
Adult FASD Assessment Clinic, Glenrose Rehabilitation Hospital	Edmonton
Date of 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

NAME of Agency, Program, and contact information for the Representative (or assigned Representative)

Phone	**Address**	**City/Town**	**Province**	**Postal Code**

Purpose(s) of disclosure

To allow the Advocate/Mentor/Representative to assist the patient/client throughout the Adult FASD Assessment Clinic process (pre, mid and post 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 power 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) indentified above. I understand why I have been asked to disclose my individually indentifying 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)***

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

Alberta Health Services

Consent to Disclose Health Information

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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)*
Demographic and clinical information needed to inquire about prenatal alcohol exposure.

Identify below where records exist (GRH Adult FASD Assessment Clinic is releasing information to request/secure information or records)

Health service provider, hospital, clinic program	City/Town
Adult FASD Assessment Clinic, Glenrose Rehabilitation Hospital	Edmonton
Date of 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
(add name of person to contact and their phone number(s) Name: _____

Phone ** _____	Address	City/Town	Province	Postal Code

Purpose(s) of disclosure
To confirm prenatal alcohol exposure.

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 power and duties of the guardian (or trustee)

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