Assessment and Diagnostic Clinic Services
Unit 103-108 Wolverine Drive
Fort McMurray, AB T9H4Y7

NEAFAN FASD Clinic Services
Referral Package

Thank you for your interest in the FASD Assessment and Diagnostic Clinic. The following package contains an overview of what to expect during this process, the referral form and our contact information.

***Please note that all adult clients must have a Designated Support Person to assist them through the clinic process. The intent of the designated representative is to ensure the client has the best opportunity to apply the recommendations from the assessment. ***

Who is the Clinic for?

The FASD Clinic is for children (age 7+) and adults experiencing difficulties that are suspected to be a result of **prenatal exposure to alcohol**. These individuals may have difficulty with education, social skills, organization, employment and independent living.
***Confirmation of prenatal alcohol exposure is required. The Clinic Lead can 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 NEAFAN), health care and other agency professionals, or personal sources including family, adoptive parents, guardians, or caregivers.

Self-referrals can also be accepted provided the individual is connected to supports and has a designated representative to assist them through the application and assessment process.

What happens after the referral is submitted?

The client's information is reviewed by the Clinic Lead, and an interview will be completed with the referral source. If pre-screening requirements are met, the client and their representative will attend an intake meeting to complete consents for the clinic to access records including health and educational records, as well as other relevant documentation such as mental health and social service records; as well as contact their sources for confirmation of Prenatal Alcohol Exposure. **It may take up to three months or longer** for these records to be received. An extensive record review determines if the client fits the Canadian diagnostic criteria for FASD. Once Prenatal Alcohol Exposure is confirmed and all other information is obtained, the client is

placed on the waitlist and required to check in with clinic quarterly (personally, or representative) to keep their file active.
**If there is no contact with a client/representative for 6 months, they will be removed from the waitlist.*

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 extent of brain damage 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. ****Not all applications will proceed for a full assessment/diagnosis. ****

What happens in the assessment process?

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

The assessment will consist of at least 2-3 sessions and more time may be required for further consultation.
Clients and/or their family members/caregivers will be interviewed by the Clinic Lead. Clients will complete approximately 6-8 hours of testing (over 2-3 days) with the Clinicians to assess abilities.
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:

- Assessment Clinic overview
- Referral Information Form
- Consent for Representative (for Adult Clinic Clients only)

Please send the completed package via email to:

Clinic Lead – Marguerite Fitzpatrick
Email: marguerite.fitzpatrick@ahs.ca

NEAFAN
Northeast Alberta FASD Network

Date Received:

NEAFAN FASD Clinic Services

Referral Form

Date: _____

1. REFERRAL SOURCE INFORMATION

Who initiated the Referral? _____

Name of Individual Making Referral: _____

Relationship to Individual: _____ Agency: _____

Phone: _____ Email: _____

Is client aware/do we have permission to contact:_____

2. CLIENT INFORMATION – *Adults-Please provide a copy of Identification (if available)

Client's Name: _____Birth Date: (D/M/Y):_____

Alberta Health Care #_____

☐ Female ☐ Male ☐ Non-Binary/ Gender Fluent ☐ Other

Preferred Pronouns: _____

Client's Address: _____

City: _____ Province: _____ Postal Code: _____

Client's Telephone: Home_____ Work_____ Cell_____

Cultural Origin: _____ Band name (if applicable): _____

Treaty Status: YES ☐ NO ☐

If Yes, Treaty #_____

Hospital Where Born: _____Address of Hospital: _____

Dependents: _____ Age of Dependents: _____

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

3. CAREGIVER INFORMATION (if applicable)
Name of Individual(s): _____

Relationship to Individual: _____

Address: _____

Phone: _____ Email: _____
Attach copy of custody/guardianship order

4. BIRTH FAMILY INFORMATION
Biological Mother's Name: _____
Address: _____
Phone: _____ Email: _____
Biological Father's Name: _____
Address: _____
Phone: _____ Email: _____
Is there current contact: _____

5. SERVICES/SUPPORTS/AGENCY INVOLVEMENT
Is Child and Family Services currently involved? Yes _____ No_____ Unknown _____
If yes, is there an order in place? _____
Name of Caseworker: _____Agency: _____
Phone: _____ Fax: _____
Has Child and Family Services ever been involved (as a child or adult)? Yes _____ No _____
When? _____ Where? _____

Name of Family Doctor: _____ Clinic: _____
City: _____ Phone: _____

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:_____

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 & location of last school attended: _____
Last year attended: _____

6. ASSESSMENT AND DIAGNOSIS
Why is an assessment being requested?

What do you know about the individual that leads you to believe he/she may have FASD?
_____
_____
_____

What are the expectations/perceived benefits of an FASD Assessment and possible diagnosis?_____
_____

Is client willing to connect and engage with other service providers as per recommendations that may arise from final reports?
_____ _____

What coping strategies does the individual currently use?_____
_____
_____

Has there been confirmation of prenatal alcohol exposure? _____
_____
_____

What is the source of confirmation of prenatal alcohol exposure?

Birth Mother _____Birth Father_____
Other Relative (If yes, describe relation) _____
File records (If yes, which records) _____
Other_____

Contacts for confirmation of prenatal alcohol exposure (PAE):
Name and contact information (relationship):_____
_____
Is individual aware we will be contacting them for the purpose of Prenatal Alcohol Exposure confirmation for this client? _____
_____

Previous FASD Diagnosis Yes _____ No_____ Unknown_____
If yes, Name of Professional that compiled: _____ Address: _____
Diagnosis: _____ Date Assessment Completed: _____

Have there been any other assessments completed? (IE: Ed-Psych, Neuro-Psych, Functional)
Please List_____
_____

PLEASE ATTACH COPIES OF ANY PREVIOUS ASSESSMENTS

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	___Behavior	___Speech
___Work/School Readiness	___Memory	___Emotional	___Language
___Health/Lifestyle Concerns	___Attention Problems	___Social	___Medical

___Other concerns_____

Is the individual dealing with a current addiction to drugs &/or alcohol?
If yes, please list all substances & length/level of use: _____
_____
_____

Is the individual currently in recovery from addiction to drugs &/or alcohol?
If yes, please list substances used & how long the individual has been in recovery: _____
_____

Does the individual have any current legal issues/probation/court dates?
If yes, please describe: _____
_____

Are there any safety concerns for staff with this individual? _____

Is this assessment required for any other applications?
AISH_____ PDD_____ Public Guardian/Trustee_____ Court_____

7. WHAT ARE THE STREGNTHS AND INTERESTS OF THE INDIVIDUAL?

_____
_____
_____

8. DOES THE CLIENT HAVE KNOWLEDGE OF FASD AND WHY THIS REFERRAL IS BEING MADE?

_____
_____

Please add any additional information you think would be helpful:

_____
_____
_____
_____
_____
_____

NEAFAN FASD Clinic Services
ADULT CLINIC
Consent for Assessment and Representation Form NEAFAN

Consent for Designated Support

I, _____ consent to have an assessment for Fetal Alcohol Spectrum Disorder
Client Name
I grant permission for _____ to serve as my support person and representative
Designated Support
throughout my involvement with the Adult FASD Assessment Clinic.
This role includes, but is not limited to, serving as the primary contact person, arranging my appointments, helping me plan transportation, attending Clinic Day, receiving the final FASD Medical Report and assisting me with assessments, recommendations and management plan.

Acknowledgement of Designated Support

I, _____ agree to serve as the representative for _____
Designated Support *Client Name*
throughout the Adult FASD Assessment Clinic process. I recognize that accepting the role of representative may include, but is not limited to, serving as the primary contact person, arranging the client's appointments, supporting them in sourcing transportation, attending Clinic Day, receiving the final FASD Medical Report, supporting the client throughout the entire process and assisting them with assessments, recommendations and management plan.

Phone Number: _____ Email: _____

_____ _____
Representative's Signature Date

_____ _____
Client's Signature Date