



# GRANDE PRAIRIE ASSESSMENT TEAM

9351 - 116th Avenue  
Grande Prairie, Alberta T8V 6L5  
Tel: 539-0333  
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FORM 214L  
2009-2010

## C.A.S.E. – G.P.I.T.

### Referral and Consent for Service from the Grande Prairie Assessment Team

Do not separate the pages of this referral package until it is completed by both school and family.

**Statement of Release of Information** – page 5 & 6, please complete **ONLY** if there are medical or other reports to be accessed.

The school is responsible to obtain written informed consent from parents(s)/guardian(s) prior to commencement of the service(s) requested.

### School Information – To be completed by School

**Student's Name** \_\_\_\_\_ Gender \_\_\_\_ Date of Birth \_\_\_\_\_ Grade \_\_\_\_ AM/PM  
(Please Print) FIRST SURNAME Y M D M-T-W-Th-Fr

Student Address \_\_\_\_\_ City \_\_\_\_\_ Postal Code \_\_\_\_\_

**Diagnosis:** \_\_\_\_\_ With documentation

Student's Alberta Learning Severe Disability Code- *Please circle:* 41 43 44 45 46 47 55 56  PUF  Not Coded

School \_\_\_\_\_ Jurisdiction \_\_\_\_\_

Teacher \_\_\_\_\_ Teacher E-mail Address \_\_\_\_\_

School Telephone \_\_\_\_\_ Program Supervisor \_\_\_\_\_

Principal \_\_\_\_\_ Principal's Signature\* \_\_\_\_\_

\*This signature, in conjunction with the parents' signature, represents authorization for the Grande Prairie Assessment Team to become involved in assessment, consultation and inservice for the above named student.

**Background information must be attached** (e.g., recent assessment, doctor's reports, and medical diagnosis)

### Parent/Guardian Information – To be completed by Parent/Guardian

**Father/Guardian** \_\_\_\_\_ Relationship to Student: \_\_\_\_\_

Living with Student Yes \_\_\_\_ No \_\_\_\_ Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_

**Mother/Guardian** \_\_\_\_\_ Relationship to Student: \_\_\_\_\_

Living with Student Yes \_\_\_\_ No \_\_\_\_ Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_

### **FOR OFFICE USE ONLY!**

Photo Consent: \_\_\_\_ New: \_\_\_\_ Status: \_\_\_\_  
Renewal: \_\_\_\_ Reports Requested: \_\_\_\_

Date Circulation began:	_____	_____	_____	_____	_____	_____	_____	_____
Disciplines:	HI	EP	NUR	OT	PT	PSY	SLP	VIS
Time Est.:	_____	_____	_____	_____	_____	_____	_____	_____
Staff:	_____	_____	_____	_____	_____	_____	_____	_____
Est. Date of Service:	_____	_____	_____	_____	_____	_____	_____	_____

**To be completed by School**

**Background Information**

**Student's Name** \_\_\_\_\_

**Reason for Referral:** What are the student's most immediate educational needs & why?

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**Request for Disciplines: (Please check)**

**Type of Service Needed (Please check)**

**Consult for the Deaf**

**and Hard of Hearing**

Assessment

Consult

Inservice

**Educational Programming**

Assessment

Consult

Inservice

**Physical Therapy**

Assessment

Consult

Inservice

**Psychology**

Assessment

Consult

Inservice

**Consultant for the**

**Visually Impaired**

Assessment

Consult

Inservice

**Occupational Therapy**

Assessment

Consult

Inservice

Direct Therapy (*GPPSD only*)

Classroom Consultation (*GPPSD only*)

**Speech-Language Pathology**

Assessment

Consult

Inservice

Direct Therapy (*GPPSD only*)

Classroom Consultation (*GPPSD only*)

Please attach a sheet to the back if you have additional information.

**List specific service requests,** (e.g. ASD inservice, Life skills inservice, fine motor assessment, educational modification assistance, speech program, classroom consultation, psychological assessment; etc.)

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**In order to complete the referral process, submit this form to GPAT along with the following documents if available:**

- Current IEP / IPP (if available)
- Referral of GPAT Services – Home Information Form
- Ophthalmology Report (if Vision support is requested)
- Audiogram (if Audiology or Hearing support is requested)
- Release of Information form (if applicable)
- Any other reports:
  - Audiology
  - Occupational Therapy
  - Physical Therapy
  - Psychology
  - Speech-Language Pathology
  - Optometrist/Ophthalmologist
  - Other (specify)

Please ensure that the Release of Information forms are completed if there are relevant medical or other records to be accessed.

## To be completed by parent/guardian

### Student Information

Student's Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_  
YEAR MONTH DAY

Alberta Health Care #: \_\_\_\_\_

Family Physician: \_\_\_\_\_

Other Physician \_\_\_\_\_

Medication: \_\_\_\_\_

For: \_\_\_\_\_

Allergies: \_\_\_\_\_

**Parent Concerns-** (Please describe concerns/behaviors/needs that you feel will be helpful in working with your child)

\_\_\_\_\_  
\_\_\_\_\_

**Relevant Child History** (medical, past assessments, counseling)-Please attach relevant assessments.

\_\_\_\_\_  
\_\_\_\_\_

What do you consider to be the most important educational focus for your child at this time?

\_\_\_\_\_  
\_\_\_\_\_

My child currently receives support services from the following agencies, (e.g.: HCS, CNIB, Glenrose, Community health) and / or private practice providers (e.g. O.T., SLP, P.T., or Psych)

\_\_\_\_\_  
\_\_\_\_\_

**A copy of report will be provided to the school. The school will share the information with the parent/guardian.**

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To be able to provide educational support services to your child, we need to ask you for some personal information.

Pursuant to the school Act, the Student Record Regulation and the Freedom of Information and Protection of Privacy Act, the School Jurisdiction may disclose to the Grande Prairie Assessment Team, relevant information in your child's Cumulative Record. The Grande Prairie Assessment Team may speak to your child's teachers, principal, education assistants and other personnel regarding your child's educational needs.

The Provincial Freedom of Information and Privacy Act protects how our personal information is collected, used and disclosed. Information acquired through this form is kept secure and access is restricted. Questions regarding the collection of this information should be addressed to the GPAT Director at 9351 – 116 Avenue, Grande Prairie, AB T8V 6L5, or by calling (780) 539-0333.

## To be completed by parent/guardian Consent for Service

### INTERVENTION

I consent to \_\_\_\_\_ receiving services from the Grande Prairie Assessment Team for  
name

Services may include:

● Audiology	● Educational Programming
● Hearing	● Nursing(Crystal Park School Only)
● Occupational Therapy	● Psychology
● Physical Therapy	● Visual
● Speech-Language Pathology	

I understand that service may be provided by one or more of these consultants. I also understand that consultation and inservice may be provided to school staff, parents and others involved in educational programming for this student

Copies of reports about my child will be sent to the teacher, superintendent / principal / physicians / medical specialists, and if necessary, to other members of the Grande Prairie Assessment Team. I declare that the information supplied on this form is, to the best of my knowledge, accurate.

**Signature of parent / guardian:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Signature of witness:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**OR**

**No Intervention Requested** \_\_\_\_\_ **Date:** \_\_\_\_\_

### PHOTO CONSENT

I give permission for \_\_\_\_\_ to be photographed, videotaped or audiotaped  
Name of child

During classroom instruction or assessment and for that material to be used with professional audiences and in presentations made by the Grande Prairie Assessment Team.

**Permission is granted** \_\_\_\_\_ **Date:** \_\_\_\_\_  
Signature of Parent / Guardian

**OR**

**Permission is not granted** \_\_\_\_\_ **Date:** \_\_\_\_\_  
Signature of Parent / Guardian

### RELEASE OF INFORMATION

I consent to the Grande Prairie Assessment Team releasing information to and receiving information from audiologists and regional Health Authority Professionals about \_\_\_\_\_  
(Name of child)

**Signature of parent / guardian:** \_\_\_\_\_ **Date:** \_\_\_\_\_

# **Statement of Release of Information**

## **ONLY TO BE COMPLETED IF THERE ARE REPORTS TO BE ACCESSED**

To authorize release of information to the Grande Prairie Assessment Team, a parent or legal guardian **must initial beside each agency** with which their child has been involved, and **sign and date** at the bottom of the page.

For Capital Health Authority (Edmonton Hospitals) please use the separate sheet.

*Please complete as fully as possible.*

**Child's Name:** \_\_\_\_\_ **Birthdate:** \_\_\_\_\_  
YEAR MONTH DAY

**Please Initial**

- Alberta Children's Hospital \_\_\_\_\_
- Local Health Unit: Name: \_\_\_\_\_  
Or Regional Health Authority: Name: \_\_\_\_\_
- Local Early Intervention Program: Name: \_\_\_\_\_
- ERECS (Edmonton) and/or R.E.A.C.H. (Calgary) Name: \_\_\_\_\_
- Student Health Initiative Program: Name: \_\_\_\_\_
- Optometrist & Ophthalmologist: Name & Address: \_\_\_\_\_
- Audiologist: Name & Address: \_\_\_\_\_
- Child's Physician:
  - a. Name & Address: \_\_\_\_\_
  - b. Name & Address: \_\_\_\_\_
- Psychologist: Name: \_\_\_\_\_
- Other: Please Specify: \_\_\_\_\_

Parent/Guardian  
Signature: \_\_\_\_\_ Date: \_\_\_\_\_ Witness: \_\_\_\_\_



**Consent for Disclosure of Health Information**

I.D. Number \_\_\_\_\_

- |   |                                       |   |   |
|---|---------------------------------------|---|---|
| <input type="checkbox"/> Community Care and Public Health | <input type="checkbox"/> Glenrose RH  | <input type="checkbox"/> Misericordia CH          | <input type="checkbox"/> Stollery Children's Hospital   |
| <input type="checkbox"/> Edmonton General CCC             | <input type="checkbox"/> Grey Nuns CH | <input type="checkbox"/> Northeast CHC            | <input type="checkbox"/> Sturgeon CH                    |
|   | <input type="checkbox"/> Leduc CH     | <input type="checkbox"/> Royal Alexandra Hospital | <input type="checkbox"/> University of Alberta Hospital |

I hereby authorize the above designated facility to disclose my individually identifying health information from the health record specified below in accordance with section 34 of the Health Information Act.

Patient / Resident / Client \_\_\_\_\_  
(SURNAME) (FIRST NAME)

Personal Health Number \_\_\_\_\_ Date of Birth (day/month/year) \_\_\_\_\_

Information to be disclosed: (please be as specific as possible) \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Information to be disclosed to: (specify name and address of person / agency to whom information is to be disclosed):  
\_\_\_\_\_  
\_\_\_\_\_

To assist in determining the appropriate information to disclose, what is the purpose of this disclosure?  
\_\_\_\_\_  
\_\_\_\_\_

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. I understand that I am responsible for any costs that may be associated with this request in accordance with the fee schedule.

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

\_\_\_\_\_  
Signature of Patient / Resident / Client / Authorized Representative  
\*Authorized Representative - attach a copy of your authority to act.

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Witness

(please print)  
Parent or Guardian Name: \_\_\_\_\_  
Address: \_\_\_\_\_  
City, Province, Postal Code: \_\_\_\_\_  
Home Phone: \_\_\_\_\_