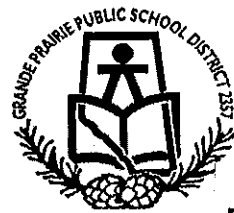




GRANDE PRAIRIE ASSESSMENT TEAM

9351 - 116th Avenue
Grande Prairie, Alberta T8V 6L5
Tel: 539-0333
Fax: 539-7613



FORM 214L
2011-2012

C.A.S.E. – G.P.I.T.

Referral and Consent for Service from the Grande Prairie Assessment Team

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

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 _____

Email: _____

Mother/Guardian _____ Relationship to Student: _____

Living with Student Yes _____ No _____ Home Phone _____ Work Phone _____ Cell Phone _____

Email: _____

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?

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

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

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.

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:

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

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 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: _____