This form is to be completed only after the subject content has been explained and discussed with the parent/guardian for the purpose of obtaining informed consent.

I/We:

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

Name of Parent/ Legal Guardian / Youth Address

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

Name of Parent/ Legal Guardian / Youth Address

hereby consent to have this referral for

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

Name of young person Date of birth (year/month/day)

reviewed by the **Halton’s FASD Assessment and Diagnostic Team** to determine eligibility for assessment. This Team includes representatives from ROCK Reach Out Centre for Kids (Psych), Halton District School Board (SLP), Halton Catholic District School Board (Psych), ErinoakKids (SLP), Halton Region-Children’s Services (OT) and Dr. Arinder Malik, Pediatrician.

**We acknowledge and understand as explained to us:**

a) The information provided is required for the referral process. The paper copy is stored in a secured environment provided by ROCK and cannot be released or shared with anyone other than the FASD Assessment and Diagnostic Team without your written consent.

b) Confidentiality, its limits and our duty to report (see reverse)

c) Aggregate data from the referral process may be shared with other agencies/funders with all identifying information removed (For example, wait list or number of referrals information could be provided.)

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Signature of Parent/Legal Guardian/Youth Date

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

Signature of Parent /Legal Guardian/Youth Date

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

Signature of witness Date

**Unless revoked this consent is valid for 1 year from date signed.**

**NOTE:**

1. This consent may be rescinded or amended in writing at any time prior to the expiration date, except where action has already been taken on the authority of the consent.
2. Confidentiality: All information is held in strict confidence and will not be shared with anyone else without your written permission. There are however, limits to confidentiality, when the staff members under very special circumstances will have to disclose information without your consent. These situations are:

* Life threatening situations (e.g. suicide, homicide, grave medical emergency)
* Where child abuse is known or suspected to have occurred
* Please be aware that the information that you share in the referral package are kept at ROCK in a file. ROCK works hard to keep information in the file confidential. However, there have been cases where ROCK has been court ordered to share information about your child’s service and we have had to do so.
* Duty to Report

Confidentiality is limited by conditions imposed by law where a person discloses:

* Harm to themselves or another (physical, sexual, emotional)
* Intention to hurt themselves
* Intention to hurt another person *or*
* Where a team/staff member has reason to suspect that a young person has been or is currently being harmed or at risk of harm.

Under these conditions our team/staff members have a professional and legal “duty to report” the information they have received to the appropriate authorities (e.g. Family and Children Services, Police).