

Case Conference Request Fax Cover Letter

Please deliver the following:	Date:	Number of pages with cover:
To: Alberta Parlee or Joanne Abrahams	From:	
Company Name: Halton Region	Company:	
Tel: 905-825-6000 ext 2500 (Alberta) or ext 2598 (Joanne)	Tel:	
Fax: 905-825-8821	Email:	
Re: FASD Case Conference Request		

Comments:

Please see the attached referral and consent for a case conference with the Halton FASD Resource Team.


Included in this fax:

Mandatory:

- Signed consent from the family/individual
- Referral form

Optional, but preferred:

- Psychological Assessment(s)
- Current IEP
- *will provide these documents at a later date, but prior to conference



Have you scheduled a second meeting for your team yet? We recommend a follow up meeting is scheduled within ~2 weeks of the conference to review roles and next steps.

*** Sender will receive confirmation of referral by email***

Confidentiality Clause

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Halton FASD Conference Referral Form – 2019/2020

Conference requested by: _____

Date: ____/____/____
YR MO DY

Please indicate with a check mark which date(s) you were hoping to have your case conference. Please note case conferences are approximately 90 minutes in length. Start times can be flexible.

September 30th _____ October 28th _____ November 25th _____
January 27th _____ February 24th _____ March 16th _____
April 20th _____ May 25th _____

Your relationship to the client: _____

Your Agency or Organization: _____

Your contact information: Phone: _____ Email: _____

Client Information:

Name: _____ Gender: _____ DOB: ____/____/____
YR MO DY

Address of primary residence: _____

Legal Guardian (if client is a child): _____ Client lives with: _____

Family Doctor / Pediatrician: _____

Caregiver information:

Parent/Caregiver 1:

Parent/Caregiver 2:

Name: _____ Name: _____

Relation to child: Mother Father _____ Relation to child: Mother Father _____

List any other services currently involved with this child or family:

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Client: _____

D.O.B: _____

Diagnosis and Assessments:

FASD is Suspected Diagnosed

If diagnosed, Date: ____/____/____ By Whom: _____
YR MO DY

Other Diagnoses: _____

Recent assessments (mental health, educational, or social functioning). Please List (Date and By Whom).

****Please include assessment report with referral if possible.*

Contact Joanne Abrahams with questions at (905) 825-6000, ext. 2598

School Information:

Name of School: _____

Is there an IEP? Yes No ** If yes, please include with referral if possible.

Issues or Questions from the school:

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Client: _____

D.O.B: _____

1. What is the focus or purpose of this conference?

2. Please provide questions you want answered from this conference?

3. Please list who will be attending the conference (i.e family, child care providers, educators, doctors etc). Please list name, role and organization.

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Consent to Disclose Personal Information

Halton FASD facilitates conferences to review the needs of children and/or youth with FASD or suspected FASD and to provide families and professionals opportunities to develop their knowledge, skills and competence regarding FASD and how best to support the individual.

In order to prepare for and proceed with a conference, information about the child/youth in your care will need to be disclosed, in oral and written format, to the members of the ***Halton FASD Resource Team**. **This form serves as your written consent for the disclosure of information to the Halton FASD Resource Team.**

I (Name of Parent or Caregiver): _____

have reviewed the Halton FASD Conference Referral Form and consent to its completion and disclosure, which includes disclosure of relevant assessments, to the Halton FASD Resource Team by:

Name of professional/organization: _____

Pertaining to:

Name of Individual: _____ DOB: _____

I understand that all written materials that are shared with the Halton FASD Resource Team will be returned to me upon completion of the conference and that copies will not be retained. I am also aware that the Halton FASD Resource Team will not generate or keep any written reports or documentation about the conference.

I am aware that members of the Halton FASD Resource Team have a legal responsibility to report reasonable grounds of suspicion of any form of harm to a child and that in such situations, confidentially will not be kept.

I agree that this consent will remain in effect for three (3) months following the date of signature unless I withdraw my consent in writing prior to information being shared and/or the conference taking place. I understand that the Halton FASD Resource Team will keep a copy of this consent form for one year after completion of the conference and that only non-identifying information may be kept for statistical purposes to support funding: for example, date of conference, location and age.

Name of Parent/Caregiver (Print)

Signature of Parent/Caregiver

Date

***Halton FASD Resource Team** consists of the following service providers: Reach Out Centre For Kids, Halton Children's Aid Society, Halton Region Children's Services, Woodview Mental Health & Autism Services, Halton District School Board, Halton Catholic District School Board, Community Living Burlington, Community Living North Halton, ADAPT, Elizabeth Fry Society, Halton Regional Police Service, Nelson Youth Centres, Milestone Foster Homes

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