



Manitoba Keyworker Referral Form

Referral Information

Date: _____
Referral Source (Please Circle)
Diagnostic Coordinator FASD Justice Self School Family Other: _____
Referral Source Name: _____ Phone Number: _____
Email: _____

Youth Information

(Please complete one referral package per youth, even if they are from the same family)

Name:	D.O.B.:
Pronouns:	PHIN:

Family & CFS Information

Parent/Caregiver Names:		
Address:	City:	Postal Code:
Home Phone Number:	Cell Number:	
Email(s):		
Is the caregiver aware of the referral? Y / N	Is the youth aware of the referral: Y / N	
Is the youth in CFS care? Y / N If yes, please provide agency information below.		
Agency Name:	Agency Worker:	
Address:	City:	Postal Code:
Phone Number:	Email:	





Informed Consent

(if referral source is unable to obtain guardian signature, please leave this section blank and it will be obtained by the Manitoba Key Worker Program)

Guardian Name:

Contact Information:

Involvement in the Manitoba Key Worker program is entirely voluntary, and you may stop your involvement at any time. Any personal information you share is protected by the Protection of Privacy provisions of the Freedom of Information and Protection of Privacy Act and the Personal Health Information Act. It will not be shared with others without your written permission, except in cases where you or someone else is in danger of being harmed, or if the disclosure of this information is required by law.

Guardian Signature: _____

FASD Assessment Information

Does the youth have an FASD Diagnosis? Y / N	
If yes, when and what was the diagnosis?	
Is an assessment attached to this referral? Y / N	If not, why?
If no diagnosis, is there Confirmed Prenatal Alcohol/Drug Exposure? Y / N	
Please provide a brief summary regarding the prenatal alcohol exposure in this pregnancy.	
Has the youth been involved with a FASD Diagnostic Coordinator previously? Y / N If yes, who? _____	
Any additional assessment/diagnosis details:	





School/Daycare Information

School/Daycare Name:		Grade:
Contact Person:		
Phone Number:	Email:	

Reasons for Referral

(Please circle all that apply)

<p><u>Caregiver Support</u></p> <p>Advocacy Increase knowledge of FASD In-Home Strategy Support</p> <p>Wraparound Support Other: _____</p>
<p><u>Youth Support</u></p> <p>Service Navigation Wraparound Support Educational Support and Navigation</p> <p>Diagnostic Education with Youth Age of Majority Other: _____</p>

Please list the names of all services involved at the time of referral below:

Speech Language Pathology:	
Occupational Therapy:	
Children's disAbility Services:	
Community Living disAbility Services:	
Mental Health:	
Justice:	
Addictions Services:	
Child and Family Services:	
Other:	



SERVICE COORDINATION AGREEMENT FOR RELEASE OF PERSONAL AND/OR PERSONAL HEALTH INFORMATION

SECTION 1: PURPOSE OF THE CONSENT

I consent to sharing of my personal information and/or health information between the agencies indicated below. The purpose of sharing information about me is to allow the service providers from each agency to discuss my situation and develop a complete service plan that will address my health and social service needs.

SECTION 2: CONFIDENTIALITY

I understand the information shared will be on a need to know basis only. It is also my understanding that each of the participating agencies will maintain confidentiality over the information in accordance with standard agency policies, legislation such as *The Freedom of Information and Protection of Privacy Act* (FIPPA) and *The Personal Health Information Act* (PHIA) and other applicable legislation.

SECTION 3: ORGANIZATIONS / AGENCIES INCLUDED IN THE PLANNING PROCESS

Please specify organization/agency (e.g. Family Services, Interlake-Eastern Regional Health Authority, or other agency) and program (e.g. Child and Family Services, Community Mental Health Services) within each organization/agency and name of service provider:

Name of Organization/Agency:

Program:

Service Provider:

_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

SECTION 4: EXPIRATION OF CONSENT

This consent shall start on the date that I sign this form and will automatically end one year later. I know that I can withdraw my consent or make changes to it at any time by contacting my lead service coordinator. I also understand that none of the organizations/agencies can share my personal information or personal health information without obtaining another consent from me unless required by law.

SECTION 5: QUESTIONS

Should you have any questions about how your personal information or personal health information is being used, please discuss your concerns with your service provider.

SECTION 6: SIGNATURES

Client _____ DOB _____
LAST NAME FIRST NAME DD/MMM/YYYY

Street Address: _____

City: _____ Postal Code: _____

Client Signature: _____ Date: _____

**SECTION 7:
CONSENT ON BEHALF OF SERVICE RECIPIENT IN ACCORDANCE WITH SECTION 60 OF THE
PERSONAL HEALTH INFORMATION ACT**

I _____
am exercising the rights for the service recipient in accordance with the *Personal Health Information Act*,
Section 60.

- A by any person with written authorization from the individual to act on the individual's behalf;
- B by a proxy appointed by the individual under *The Health Care Directives Act*;
- C by a committee appointed for the individual under *The Mental Health Act* if the committee has the power to make health care decisions on the individual's behalf;
- D by a substitute decision maker for personal care appointed for the individual under *The Vulnerable Person's Living With A Mental Disability* if the exercise of the right is related to the power and duties of the substitute decision maker;
- E by the parent or guardian of an individual who is a minor. Or if the minor does not have the capacity to make health care decisions; or
- F if the individual is deceased, by his or her personal representative

**CONSENT ON BEHALF OF SERVICE RECIPIENT IN ACCORDANCE WITH THE FREEDOM OF
INFORMATION AND PROTECTION OF PRIVACY ACT**

I _____
am exercising the rights for the service recipient in accordance with the *Freedom of Information and
Protection of Privacy Act*, Section 79.

- A by any person with written authorization from the individual to act on the individual's behalf;
- B by a committee appointed for the individual under *The Mental Health Act* if the committee has the power to make health care decisions on the individual's behalf;
- C by an attorney acting under a power of attorney granted by the individual. If the exercise of the right or power related to the powers and duties conferred by the power of attorney;
- D by the parent or guardian of a minor when, in the opinion of the head of the public body concerned, the exercise of the right or power by the parent or guardian would not constitute an unreasonable invasion of the minor's privacy; or
- E if the individual is deceased, by the individual's personal representative if the exercise of the power or right relates to the administration of the individual's estate.

Signature of Individual on Behalf of the Service Recipient:

Print Name _____
Last Name First Name

Relationship _____

Date: _____ Telephone #: _____