

FASD Assessment and Diagnostic Collaborative Request for Service

Centre for Behaviour Health Sciences, a department of Mackenzie Health, is funded to provide assessment/diagnosis in the Central LHIN and works in partnership with Waypoint Centre for Mental Health Care for service provision in the North Simcoe Muskoka LHIN.

CLIENT INFORMATION			
Name: _____	Telephone (H): _____		
Address: _____	Telephone (B): _____		
_____	Date of Birth: / /		
_____	day month year		
Postal Code: _____	Gender: Male <input type="checkbox"/>		
Email Address: _____	Female <input type="checkbox"/>		
Health Card #: _____	Other <input type="checkbox"/>		
Version Code: _____	Health Card Expiry Date: _____		
CONSENT SOURCE (If completed by someone other than the client)			
Name: _____	Telephone: _____		
Address: _____	Relationship To Client: _____		
_____	_____		
Postal Code: _____	_____		

I, _____ have reviewed this information and give permission for its release to
(Consent Source)

Centre for Behaviour Health Sciences, Mackenzie Health, on behalf of _____.
(Client)

Consent Source Signature

Date

Client Signature

Date