



Consent form For Neurodevelopmental Disorder Assessment and Treatment

Children under the age of 18 years require parental/guardian consent to access services at our clinic.

Both parents' signatures are required, including situations where parents are separated or divorced and there is joint custody or no formal custodial arrangement.

If both parents/guardians are unable to sign this Parent Consent form, please refer second parent/guardian to our clinic <https://www.lifebridgehealth.ca>.

Child's Full Legal Name

First Name

Last Name

Child's Date of Birth

mm/dd/yyyy

Parents' Relationship Status

Declaration and Consent

I/We, being the custodial parent(s)/guardian(s) of the above-named child, consent to the assessment and/or treatment services of said child at Lifebridge Health Centre.

I/We agree to inform the clinic, should this arrangement be changed while receiving the services.

I/We understand that both parents will have access to the child's complete chart. Please note that the chart includes all communications from both parents. Including all emails and telephone calls. Please note that non-custodial parents and parents without decision making authority retain access to the chart, unless there is a court order stating otherwise.

#36 – 118 Cope Crescent, Saskatoon, SK S7T 0X3
Phone 306-955-LIFE (5433) Fax 306-955-5690
www.lifebridgehealth.ca



Purpose and process of assessment, implications for diagnosis (or lack thereof), limits of confidentiality, release of formal reports and opportunity to decline and withdraw from services at any time were explained.

I have the right to withdraw my consent for evaluation and/or treatment of my child at any time by providing a written request to the treating clinician.

I have read and understand the above, have had an opportunity to ask questions about this information, and I consent to the evaluation and treatment of my child. I also attest that I am the legal guardian and have the right to consent for the treatment of this child. I understand that I have the right to ask questions of my child's service provider about the above information at any time.

This consent will expire 12 months from the date of signature, unless otherwise specified.

Parent/Guardian Name

Please Print

Signature

Date

mm/dd/yyyy

Parent/Guardian Name

Please Print

Signature

Date

mm/dd/yyyy

Name of Witness

Please Print

Signature

Date

mm/dd/yyyy

Physician

Please Print

Signature

Date

mm/dd/yyyy



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