Ontario

Birth Family Member's Application to Request a Severe Medical Search

If you have any questions, please contact:
ServiceOntario
Toll-free: 1 800 461-2156 or
Toronto: 416 325-8305

(THIS SPACE RESERVED FOR OFFICE USE ONLY)

BRI _____ **CID** _____

Important:
Please read through the instructions thoroughly **before** completing this form. Please **print clearly in blue or black ink**.

PART A: Applicant Information

Applicant Name

☐ Mr. ☐ Mrs. ☐ Ms. ☐ Miss	Surname (Last Name)	First Name
	Middle Name(s)	Maiden Name or Other Surname(s) *(if applicable)*

Sex ☐ Male ☐ Female	Date of Birth *(Day, Month, Year)*	

Mailing Address

Street No.	Street Name	Apt. No.	Buzzer No.	PO Box
City/Town	Province/State	Country		Postal/Zip Code

Daytime Telephone Number ( )	Ext.	Can a message be left for you at this number? ☐ Yes ☐ No	Alternate Telephone Number ( ) Ext.

Additional Information About the Applicant

Please identify if you are *(check only one box)*

☐ A birth parent of an adopted person *(check the appropriate box)*
- ☐ Birth Mother
- ☐ Birth Father

☐ A birth family member other than a birth parent. *Please specify your family relationship to the adopted person by checking the appropriate box*
- ☐ Maternal birth grandparent
- ☐ Paternal birth grandparent
- ☐ Birth sibling
- ☐ Other birth family member *(please specify your family relationship)* _____

☐ The parent or legal guardian of a birth family member who is under 18 years of age
(please specify the birth family member's relationship to the adopted person) _____

☐ Applying on behalf of a birth family member as someone with legal authority to act on the birth family member's behalf
(please specify the birth family member's relationship to the adopted person) _____

☐ Applying in regard to a deceased birth parent who suffered from a severe mental or physical illness. Please identify yourself by checking one of the following boxes *(check only one box):*
- ☐ I am the spouse of the deceased birth parent
- ☐ I am the executor of the deceased birth parent's estate
- ☐ I am a member of the College of Physicians and Surgeons of Ontario
- ☐ I am member of the College of Psychologists of Ontario or a member of the College of Nurses of Ontario who holds a certificate of registration in the extended class
- ☐ I am person who is legally authorized to practice medicine or psychology in a jurisdiction outside of Ontario
  (Name of Jurisdiction) _____

The purpose of the search is *(check only one box)*

☐ To obtain medical information
☐ To share medical information
☐ Both of the above

PART B: Information About the Adopted Person *PRIOR to* Adoption

Surname (Last Name) of Adopted Person *(at time of birth)*		
First Name	Middle Name(s)	
Sex ☐ Male ☐ Female	Date of Birth *(Day, Month, Year)*	Birth Registration Number *(if known)*
Place of Birth of Adopted Person City/Town	Province/State	Country
Legal Surname (Last Name) of **Birth Mother** *(at time of birth)*		
First Name	Middle Name(s)	Any Other Legal Surnames (Last Name)
Date of Birth *(Day, Month, Year)*	Birth Mother's Age *(at time of this birth) (if known)*	
Place of Birth City/Town	Province/State	Country
Legal Surname (Last Name) of **Birth Father** *(at time of birth)*		
First Name	Middle Name(s)	Any Other Legal Surnames (Last Name)
Date of Birth *(Day, Month, Year)*	Birth Father's Age *(at time of this birth) (if known)*	
Place of Birth City/Town	Province/State	Country

PART C: Information About the Adopted Person *AFTER* Adoption

Adoptive Surname (Last Name) of Adopted Person		
First Name	Middle Name(s)	
Sex ☐ Male ☐ Female	Date of Adoption *(Day, Month, Year) (if known)*	
Has the person named above had a legal name change after adoption? ☐ Yes ☐ No If "Yes" provide details below		
Current Legal Surname (Last Name)	First Name	Middle Name(s)
Place of Birth of Adopted Person City/Town	Province/State	Country

PART D: Health Care Professional Questionnaire

Patient Name

Surname (Last Name)	First Name	Middle Name(s)

Patient Consent to Disclose Health Information

I, _____ , hereby authorize _____ to
(Patient's Full Legal Name) *(Health Professional's Name)*

disclose any health information required to the Custodian of Adoption Information, or his or her designate, to support my application for a Severe Medical Search under section 16 of O.Reg. 464/07 made under the *Child and Family Services Act*.

_____ _____
(Signature of Applicant) *(Date of Signature)*

Important:
The following section must be completed by a physician or other regulated health care professional.
Please **print clearly in blue or black ink**.

Health Care Professional's Information

Surname (Last Name)	First Name	Middle Name(s)

Business Address 

Street No.	Street Name	Unit. No.	PO Box

City/Town	Province/State	Country	Postal/Zip Code

Daytime Telephone Number ( )	Ext.	

Health Professional's Designation (check appropriate box)

- ☐ Member CPSO (College of Physicians and Surgeons of Ontario)
- ☐ FRCP/FRCS (Fellow of the Royal College of Physicians)
- ☐ Registered Psychologist
- ☐ Nurse in Extended Category
- ☐ Other Regulated Health Care Professional Designation (please provide details in space provided)

_____

Important

The purpose of a Severe Medical Search is to locate and contact an adopted person, the descendant of an adopted person, or the birth family member of an adopted person in order to obtain or share medical information that will significantly increase the likelihood of diagnosing or treating a severe mental or physical illness.

The information obtained may benefit the adopted person, the descendant of the adopted person, or the adopted person's birth family member.

The information provided in the Health Care Professional Questionnaire is collected and will be used to determine the applicant's entitlement to a Severe Medical Search under section 16 of O.Reg. 464/07 made under the *Child and Family Services Act*. If you have any questions about the collection of information please contact: Director, ServiceOntario Call Centre, Contact Centre Service Branch, 5775 Yonge St, Toronto ON M3M 3E6 or call 1 800 461-2156 / 416 325-8305.

Description of patient's health condition.
Include the presenting problem, diagnosis and prognosis. If prevention is a factor in this request please provide any supporting evidence.

Is the health information being sought essential to the patient's diagnosis and/or treatments?
☐ Yes ☐ No If Yes, please explain your reasons.

Is there a genetic reason to seek or pass on this information?
☐ Yes ☐ No If Yes, please explain by providing further details.

Are there any adverse health effects in denying this request for a Severe Medical Search?
☐ Yes ☐ No If Yes, please explain by providing further details.

Is there any other information that you would like to provide in support of this application?
☐ Yes ☐ No If Yes, please explain by providing further details.

Signed statement by health care professional

I, _____ certify that
(Health Care Professional's Full Name and Professional Designation)

the information I have given is true and correct to the best of my knowledge and belief.

_____ _____
(Signature of Health Care Professional) *(Date of Signature)*

Please stamp below or attach a business card or letterhead

PART E: Signed Statement by the Applicant

I hereby certify that the information I have provided on this application form is true and correct to the best of my knowledge and belief.

_____ _____

(Signature of Applicant) *(Date of Signature)*

Mail your completed application, including the Health Care Professional Questionnaire to:

Custodian of Adoption Information
P.O. Box 654
77 Wellesley St. West
Toronto ON M7A 1N3

The information provided on this form is collected and will be used to determine your entitlement to a Severe Medical Search under section 16 O.Reg. 464/07 made under the *Child and Family Services Act*. If you have any questions about the collection of information please contact: Director, ServiceOntario Call Centre, Contact Centre Service Branch, 5775 Yonge St, Toronto ON M3M 3E6 or call 1 800 461-2156 / 416 325-8305.