Fetal Alcohol Spectrum Disorder (FASD) Referral Form

Client Name:

DOB:

Children's Treatment Centre

CLIENT/YOUTH INFORMATION

Last Name:		First Name:	
Date of Birth: *(dd / mmm / yyyy)*	Gender: Female Male Other	Primary Phone:	
Address:	City:		Postal Code:
School/Childcare:			
Grade:		Individualized Education Plan (IEP): Yes No	

FAMILY/PARENT/GUARDIAN INFORMATION

Language(s) spoken at home:		Is an interpreter required? Yes No	
Do the family identify as Indigenous, First Nations, Inuit or Metis? Yes No			
Is a member of the family part of the military? Yes No			
PRIMARY CONTACT	Last Name:	First Name:	
Relationship to Child:		*(if other or Agency, please specify)*	
(check all that apply)	Legal Guardian Lives with Child	I give consent for email communication	
Primary Phone:	Other Phone:	Email:	
Address is same as the child's	Address is other than child's *(if Other, provide address below)*		
Address:	City:	Postal Code:	
SECOND CONTACT	Last Name:	First Name:	
Relationship to Child:		*(if other or Agency, please specify)*	
(check all that apply)	Legal Guardian Lives with Child	I give consent for email communication	
Primary Phone:	Other Phone:	Email:	
Address is same as the child's	Address is other than child's *(if Other, provide address below)*		
Address:	City:	Postal Code:	

DECISION-MAKING RESPONSIBILITY

Decision-Making Responsibility:	No formal agreement	Formal agreement in place	Parents live together with child
If formal agreement in place, please describe (eg. sole, joint, etc.):			
If parents are not together, all legal guardians are aware of and have consented to this referral:	N/A	Yes	No (if No, referral **CANNOT** be processed)

SUPPORTING INFORMATION

Is Fetal Alcohol Spectrum Disorder (FASD) Diagnosed Suspected	
Do you have copies of the following assessments / reports?	
Occupational Therapy Assessment	Genetics Assessment
Speech and Language Assessment	Medical Assessment / Report
IPRC Committee Documents	Other *(specify)*
School IEP, Behaviour Plan, Safety Plan	Other *(specify)*
Psycho-educational assessments	
Are there co-occurring diagnoses? Yes No If yes, please list:	

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TEAM MEMBER INFORMATION

List below any agency/organization or individual that is also working with the child/youth (e.g. doctor, school, child care):

Agency/Organization Name	Contact Name / Role	Phone Number

REASON FOR REFERRAL

In your own words, describe what you are hoping for from this service:

Is there anything else you want us to know?

REFERRAL SOURCE INFORMATION

Name of Referring Individual:

Contact Phone Number: | Alternate Phone Number:

Are you a Service Provider? Yes No

If yes, Agency/Organization and Role:

Please note: referrals received from sources other than physicians require the parents'/legal guardian's signature of consent to make this referral.

Signature of parent/guardian | Name of parent/guardian | Date

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