Agency: _____

Address Phone Fax

INITIAL REFERRAL FORM

Referral Date: _____ Send NCIF: ❑No ❑Yes Date Sent: _____

Full Legal Name of Potential Client:		
Age: _____	Date of Birth: ___/___/___ (M D Y)	Place of Birth: _____
Address:	*Street Number and Name*	
	_____ *City*	_____ *Postal Code*
Phone:	Cell:	Fax:
Email:		

Name of Person Calling: _____		Agency or Organization: _____	
Address:	*Street Number and Name*	*City*	*Postal Code*
Telephone: _____		Email: _____	
Relationship to client:	❑birth parent	❑adoptive parent	❑foster parent
	❑ other :(specify)		

Birth Mother's Name:	Birth Date:
Birth Father's Name:	
Family/Support Advocate's Name:	

1. Why are you requesting an assessment at this time? _____

_____

Potential Client: _____

2. What do you know about this person that makes you believe he/she may be affected with FASD (behavior or learning problems)?

3. Is there a confirmation of prenatal alcohol exposure available? _____

4. Have you talked about the diagnosis of fetal alcohol syndrome with the client or their caregiver?

5. What previous assessments or reports have been done? For example: Child Development Centre (CDC), Education, Mental Health, Justice, Psychology, and Speech/Language.

Type of Assessment	Name of Assessor	Date of Assessment	Copies of the Report?

Name of person completing this form: _____

Comments:

_____

_____

_____

_____

_____

_____