NL Health Services

Multidisciplinary FASD Clinic Initial Referral Form – ADULT (19+ years)

Referral Date: _____ Date Received: _____
(Completed by FASD Coordinator)

Name of Referral Source:		Agency or Organization:	
Address:			
	Street Number and Name	*City*	*Postal Code*
Telephone:		Email:	
Relationship to Applicant:			
Is the individual/client aware that this referral is being made on their behalf? ❑ Yes ❑ No			

Full Legal Name:			
Age:	Date of Birth:	Place of Birth:	
MCP #:			
Address: _____			
	Street Number and Name	*City*	*Postal Code*
Phone:	Cell:	Fax:	
Email:			

Birth Mother's Name:	Birth Date:
Birth Father's Name:	

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

_____

_____

_____

2. What do you know that makes you believe you may be FASD affected (e.g. behaviour or learning problems)?

_____

_____

_____

_____

3. Is there confirmation of prenatal alcohol exposure available? ❑ Yes ❑ No

4. What previous assessments or reports have been done? For example: Education, Mental Health, Justice, Psychology, Speech Language, etc.

Type of Assessment	Name of Assessor	Date of Assessment	Copy of the reports available? Y or N

Comments: _____

_____

_____

_____

_____

_____	_____	_____
Signature of Person Completing Form	Name and Designation	Date
_____	_____	_____
Signature of Client	Name	Date