NL Health Services

Multidisciplinary FASD Clinic Initial Referral Form – CHILD/YOUTH (8-18 years)

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

Is the parent(s)/guardian aware that this referral has been made on behalf of this child/youth? ❑ Yes ❑ No

Name of Referral Source:		Agency or Organization:
Address:		
	Street Number and Name	*City* *Postal Code*
Telephone:		Email:
Relationship to Applicant:		

Full Legal Name of Child/Youth:		
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:	
Caregiver's Name:	

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

_____

_____

_____

2. What do you know about this child/youth that makes you believe they may be FASD affected (eg. 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 Parent/Guardian | Name | Date