



SHKAGAMIK-KWE HEALTH CENTRE FASD CLINIC REFERRAL FORM

1. Referral Source **Date of Referral:** _____
 Name: _____
 Agency: _____
 Telephone: _____ Email: _____
 If other than the legal guardian, is the legal guardian in agreement with this referral? Y N

2. Child/Youth Information
 Name: _____ Male Female Other
 Date of Birth: _____ OHIP #: _____
 Address: _____
 Telephone: _____
 Band Name: _____ Band #: _____
 Does the child/youth/family require the services of an interpreter? Y N
 If yes, specify language spoken: _____

3. Caregiver Information
 Name of Primary Caregiver(s): _____
 Custody Status (e.g., sole custody, joint custody): _____
 Relationship to Child/Youth:
 Birth Parent Adoptive Parent Alternative Care Parent Customary Care Parent Kinship
 Other _____
 Caregiver Address (if different from above) _____
 _____ Email: _____
 Cell Phone: _____ Home Phone: _____

4. Legal Guardianship (if different than above)
 Name of Legal Guardian(s): _____
 Name of Agency: _____
 Primary Worker: _____ Phone #: _____
 Address: _____



5. Daycare/School/ Birth Hospital Information

Name of daycare: _____

Name of school: _____ Grade: _____

Name and Location of Birth Hospital: _____

6. Reason for Referral/Presenting Concerns

- | | | |
|---|--|---|
| <input type="checkbox"/> Eating Issues | <input type="checkbox"/> Movement/Coordination | <input type="checkbox"/> Mental Health |
| <input type="checkbox"/> Sleep Issues | <input type="checkbox"/> Attention | <input type="checkbox"/> Substance abuse |
| <input type="checkbox"/> Communication/Language | <input type="checkbox"/> Transitions | <input type="checkbox"/> Trouble with the law |
| <input type="checkbox"/> Self-Care/Hygiene | <input type="checkbox"/> Attendance at school/work | <input type="checkbox"/> Memory |
| <input type="checkbox"/> Cognition/Intellectual | <input type="checkbox"/> Learning | <input type="checkbox"/> Emotional Regulation |
| <input type="checkbox"/> Social Skills | <input type="checkbox"/> Behaviour | <input type="checkbox"/> Other: |

7. Confirmation of Prenatal Alcohol Exposure

Yes No Suspected Unknown

Please Note: prenatal alcohol exposure must be confirmed before the child/youth can be eligible for assessment. If prenatal alcohol exposure is suspected, the referral will be on hold until confirmation is obtained. SKHC FASD Clinic staff can help guide the referrer/guardian through this process.

8. Previous Assessments

<input type="checkbox"/> Psychology	<input type="checkbox"/> Vision	<input type="checkbox"/> Educational
<input type="checkbox"/> Psychiatry	<input type="checkbox"/> Speech/Language	<input type="checkbox"/> Genetics
<input type="checkbox"/> Hearing	<input type="checkbox"/> OT/PT	<input type="checkbox"/> Other

9. Other Agency Involvement

Please list other services/agencies (and contact person) currently involved with this family.

