Children's Treatment Centre
Quinte Health
Belleville General Hospital
265 Dundas Street East
Belleville, ON K8N 5A9

Telephone: **(613) 969-7400 x2247**
Fax: **(613) 968-9154**
www.quintectc.com

Fetal Alcohol Spectrum Disorder (FASD) Referral Form

CONFIDENTIAL

Fax to 613-961-2529 Questions? Call 613-969-7400 x2630

CHILD/YOUTH INFORMATION

Last Name:		First Name:
Date of Birth: *(dd / mmm / yyyy)*	Gender: ☐ Female ☐ Male ☐ Other	Phone Number:
Address:		City: Postal Code:
School/Childcare:		
Grade: (select 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: (select relationship)		*(if other or Agency, please specify)*
(check all that apply) ☐ Legal Guardian ☐ Lives with Child		
Home Phone:	Mobile:	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: (select relationship)		*(if other or Agency, please specify)*
(check all that apply) ☐ Legal Guardian ☐ Lives with Child		
Home Phone:	Mobile:	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