Fetal Alcohol Spectrum Disorder (FASD) Referral Form

CONFIDENTIAL

Fax to 613-961-2529 **Questions? Call 613-969-7400 x 2630**

A. Child / Youth & Family Information:	
Last Name:	First Name:
Address:	
City:	Postal Code:
Primary #: Click here to enter text.	Alternate #:
Date of Birth (dd/mm/yyyy):	Sex: F ☐ M ☐ Other ☐
School/Childcare:	
Grade:	IEP: Y ☐ N ☐
Primary Contact Name:	
Address:	
City:	Postal Code:
Primary #:	Alternate #:
B. 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 & Language Assessment	☐Medical Assessment/Report
☐IPRC Committee Documents	☐Other:
☐School IEP, Behaviour Plan, Safety Plan	☐Other:
☐Psycho-educational assessments	
Are there co-occurring diagnoses? Y ☐ N ☐ If yes, please list:	

C. Team Member information: (Who else is working with the child / youth? ie: doctor, school, child care, etc.)**:**

Agency Name	**Contact Name, Role & Phone #**

D. Reason for Referral
In your own words, describe what you are hoping for from this service
Anything else you want us to know?

E. Referral Source Information:	
Name (Referring Individual):	
Are you a Service Provider? Y ☐ N ☐	Contact Phone #:
If Yes, Agency/Organization:	

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