

Community Referral Form Fetal Alcohol Spectrum Disorder Program

Children and Youth under the age of 18 (or 21 if still in school) who have diagnosed or suspected Fetal Alcohol Spectrum Disorder (FASD) and its effects which may include physical, mental, behavioral and learning difficulties and who would benefit from additional FASD specific support, coaching, consultation, education, community capacity building, training and resources.

Child/Youth Full Name:		Date of Birth: (dd/mm/yyyy)	Click here to enter a date.
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School			
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School Name & Board	Grade	Main Contact Name	Contact Information
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Parent/Legal Guardian	Relationship	Contact Number	Alternate Number

Email Address	<input type="checkbox"/> Consent to contact you by Email
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Best Day/Time to Contact		Preferred Method of Contact <input type="checkbox"/> Telephone <input type="checkbox"/> Email <input type="checkbox"/> Text
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Child or Youth lives with:

Both Parents *(include both parent names above)* OR Mother Father Guardian Other

Languages spoken in the home:
 Interpreter Required: Yes or No Preferred Language:

Does the family identify as First Nation, Metis or Inuit? Yes or No If yes, details:

Is the family aware a referral for service is being made? Yes or No

Other Services Involved

Name	Service/Agency Name	Contact Information

Request for Services

Support and Consultation	<input type="checkbox"/> Coaching with an FASD perspective <input type="checkbox"/> Caregiver / Family
Community Capacity Building	<input type="checkbox"/> Professional Development <input type="checkbox"/> Awareness / Information
Other	<input type="checkbox"/> Brief Case Conference <input type="checkbox"/> Training/Info Session <input type="checkbox"/> Resource Information

Additional Notes *(estimate amount of parent consultation requested, for case conference(s), estimate number of conferences to be attended; if training/information session, provide length of session requested).*

Completed By: _____ Agency: _____ Date: _____

Once completed please print and mail or fax to 519-354-7355. For more information on referral process, please contact 519-354-0520 or email info@childrenstreatment-ck.com