 **Halton FASD Assessment & Diagnostic Clinic**

**Referral for Consideration**

**1. Referral Source**

 Name:

 Agency:

 Telephone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Email:

**2. Client Information**

 Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 🞏 Male 🞏 Female 🞏\_\_\_\_\_\_\_\_\_\_\_\_\_

 Date of Birth:

 Address:

 Telephone:

**3. Caregiver Information**

 Name of Parent(s)/Guardian(s):

 Custody Status (e.g., sole custody, joint custody, no status)

 Relationship to Child/Youth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Parent(s)/Guardian(s) Address (if different from above):

 Telephone:

**4. Daycare/School Information**

 Name of daycare

 Name of school \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Grade

**5. Reason for Referral/Presenting Concerns**

 🞏 Motor Skills 🞏 Cognition

 🞏 Neuroanatomy/neurophysiology (Physical) 🞏 Language (Receptive/Expressive)

 🞏 Academic Achievement 🞏 Memory

 🞏 Affect Regulation (Anxiety, Depression, Mood) 🞏 Attention

 🞏 Executive Function (Impulsivity, Working 🞏 Adaptive Behaviour, Social Skills or Social

 Memory) Communication (Daily Living Skills)

 Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**6. Is there significant risk of 🞏 home and/or 🞏school placement breakdown? Yes / No**

**7. Pre-Natal Alcohol/Drug Exposure**

Please provide as many details as possible about the frequency, timing and amount of alcohol consumed (e.g., two episodes of binge drinking (4 or more drinks) during first trimester)

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 Amphetamines 🞏Cocaine/Crack 🞏 Ecstacy 🞏Heroin🞏Meth 🞏Marijuana 🞏\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Please explain:

**8. Post-Natal Head Injury** (known or suspected)

 Yes 🞏 No 🞏

 Please explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**9. Does the client currently have any learning, medical or mental health diagnoses?**

 Yes 🞏 No 🞏

 Please explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**10. Previous Assessments**

 🞏 Genetics Year \_\_\_\_\_\_\_ By whom? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 🞏 Psychology Year \_\_\_\_\_\_\_ By whom? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 🞏 Psychiatry Year \_\_\_\_\_\_\_ By whom? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 🞏 Hearing Year \_\_\_\_\_\_\_ By whom? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 🞏 Vision Year \_\_\_\_\_\_\_ By whom? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 🞏 Educational Year \_\_\_\_\_\_\_ By whom? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 🞏 Speech/Language (SLP) Year \_\_\_\_\_\_\_ By whom? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 🞏 Occupational Therapy (OT) Year \_\_\_\_\_\_\_ By whom? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 🞏 Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Year \_\_\_\_\_\_\_ By whom? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**11. Is the client currently on a waitlist for an assessment?**

 🞏 Psychological 🞏 Occupational Therapy 🞏 Speech and Language

 If yes please explain where, when and with whom \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**12. Other Agency Involvement**

 Please list other services/agencies currently involved with this family.

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 **Form Completed by** (if different from referral source)

 Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Contact information: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Please fax (905-681-7477) or drop off referral package, including consent,

 to ROCK, 471 Pearl Street Burlington ON, Attention: FASD Clinic Coordinator.

 If you have any questions please contact **Sue Brooks at 905-634-2347 ext. 234**