



# Fetal Alcohol Spectrum Disorder (FASD) Diagnostic Clinic – Referral Form

<b>PATIENT INFORMATION:</b>			
Date of Referral:		SH (if available):	
Name:		Gender:	
Home Address:			
Postal Code:		Date of Birth:	____ / ____ / ____ DD MM YYYY
Health Card (including version code):		Parent/Guardian:	Preferred Language: <input type="checkbox"/> English <input type="checkbox"/> French
Home Phone:		Cell Phone:	
Parent/Guardian aware and consent to referral being made	<input type="checkbox"/> Yes <input type="checkbox"/> No	Location Preference:	<input type="checkbox"/> Sudbury
Child Care Worker (if applicable):		Worker Contact:	
Current School:		Child Lives In:	<input type="checkbox"/> Family Home <input type="checkbox"/> In Care <input type="checkbox"/> Other:
Birth Hospital:		Hospital Location:	
Is the patient First Nations	<input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, please specify:	<input type="checkbox"/> Indian Status <input type="checkbox"/> Non-Status <input type="checkbox"/> Metis <input type="checkbox"/> Lives on Reserve <input type="checkbox"/> Lives Off Reserve
Does the patient practice traditional healing	<input type="checkbox"/> Yes <input type="checkbox"/> No		
<b>REFERRING SOURCE:</b>		<b>SELF REFERRAL</b> <input type="checkbox"/> Yes <input type="checkbox"/> No	
Referring Source:		Telephone:	
Email Address:			
<b>REASON FOR REFERRAL:</b>			
Is there confirmation of prenatal alcohol exposure? <input type="checkbox"/> Yes <input type="checkbox"/> No If no, please describe any steps taken to confirm exposure.			
<b>APPLICABLE INFORMATION ATTACHED</b>			
<input type="checkbox"/> Academic Records	<input type="checkbox"/> Adoption Records	<input type="checkbox"/> Birth Records	
<input type="checkbox"/> Occupational Therapy Reports	<input type="checkbox"/> Psychiatric Reports	<input type="checkbox"/> Psychoeducational Reports	
<input type="checkbox"/> Physiotherapy Reports	<input type="checkbox"/> Psychological Reports	<input type="checkbox"/> Speech Reports	

All required information regarding the **FASD Diagnostic Clinic** can be accessed at [www.hsnsudbury.ca/NEOKids](http://www.hsnsudbury.ca/NEOKids). The patient will be contacted by the **Pediatric ACU** to have their intake appointment booked. Fax form and required attachments to **(705) 523-7288** or email to [neokidsacu@hsnsudbury.ca](mailto:neokidsacu@hsnsudbury.ca).