FASD NETWORK Northwest Central Alberta

P.O. Box 125, Thorhild, AB • Fax: 780-736-2102

Adult Clinic Coordinator: Jennifer P • jennp@nwcfasd.ca • Ph: 780-974-7112

PLEASE READ BEFORE FILLING OUT A REFERRAL FORM

The criteria REQUIRED by NWCFASD Network in order to do an FASD assessment are:

Confirmation of Prenatal Alcohol Exposure (PAE) MUST accompany the submission of this referral form and MUST come from one or more of the valid sources listed below:

If birth mother is alive, confirmation of PAE MUST come from her.
If the birth mother is deceased and/or cannot be located confirmation of PAE MUST be obtained from the maternal side of the family (excluding current caregiver) and/or from agency file documentation

1. Did birth mother consume alcohol in the amount of 7 or more drinks for seven consecutive days twice during the pregnancy? Yes ☐ No ☐

2. Did birth mother consume 4 or more drinks on at least two separate occasions during pregnancy? Yes ☐ No ☐

If you did not answer yes to either of the two questions you do not meet the criteria to have an FASD Assessment done.
If you answered yes to either of the two questions and the confirmed PAE comes from one of the valid sources listed above please fill out the referral form.

Adult referrals can be faxed to 780-736-2102 or emailed to jennp@nwcfasd.ca

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Adult Assessment & Diagnostics Services Referral Form

Date: _____

Client Information

Client Name: _____ **Male** ☐ **Female** ☑ **Other** _____

Name @ birth (if different from above): _____

Date of Birth: _____ **Health Care Number:** _____

Address: _____ **Postal Code:** _____

Cell: _____ **Other:** _____

Hospital at birth: _____

Culture Origin: First Nations_____ Metis_____ Inuit_____ Caucasian_____ African American_____ Hispanic_____ Asian_____

Other _____

On Reserve: Yes ☐ No ☐

Treaty # _____ **Band:** _____ **Registered** Yes ☐ No ☐

Current Support Mentor/Agency involvement

Name:_____ Agency:_____

Phone: _____Cell: _____Fax: _____ Email: _____

Has CFS ever been involved? Yes ☐ (which location) _____ No ☐

Family Doctor: _____ **Clinic/Location:** _____

Phone: _____ **Fax:** _____

Are there any legal or pending court dates? Yes ☐ No ☐ **If so, please provide details**

_____

_____

Has there been any assessments been completed to date? Yes ☐ No ☐

If so, attach copies or list assessments and name of the professional involved

_____

_____

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Please check all areas of concern with brief explanation:

Behavioral Concerns _____ Sensory Concerns _____

Learning Difficulties _____ Adaptive Living Concerns _____

Difficulties with the law _____ Social Skills Difficulties _____

Developmental Delays _____ Income Supports _____

Substance Abuse _____ Suicide attempt/Ideation _____

Abstract Concepts (time/money) _____

Hyperactivity/Impulsivity Yes_____ No_____

What are the client's strengths and interests? _____

Cultural/Spiritual/Religious Activities? _____

Current Program Involvement

Name of schools attended: _____

Last grade attended

_____ Does the client currently attend a school or training program? Yes _____ No _____ Where_____

Is the client currently employed? Yes _____ No _____ Where _____ Part-Time _____ Full Time _____

Health History

Was the client born with (or later discovered to have) any birth defects (e.g. cleft palate, congenital heart defects, clubfoot, etc.)?

Yes _____ No _____ Unknown _____ If yes, please explain

_____

_____

Has the client had any Chronic Illnesses? If yes, please explain

_____

_____

Has this client had any hospitalizations and or surgeries since birth? Yes _____ No _____ Where _____If yes, please explain

_____

_____

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Other historical health related issues	Yes	No
Physical Abuse	☐	☐
Sexual Abuse	☐	☐
Did a physician evaluate this?	☐	☐
Emotional Abuse	☐	☐
Neglect	☐	☐
Witness to Violence	☐	☐
Other	☐	☐

Neurological/Mental Health History

Has this client ever had seizures? Yes ☐ No ☐ Head injury leading to unconsciousness? Yes ☐ No ☐

Bed-wetting or soiling after 8 yrs old? Yes ☐ No ☐ Is this still continuing today? Yes ☐ No ☐

CT or MRI scan of brain? Yes ☐ No ☐ if yes where was this completed? _____

List of Current Medications/Treatments:

_____

_____

Pregnancies of Biological Mother (including miscarriage and abortion)

Year	Length of pregnancy	Name of child	Born Alive		Normally Developed		Behavioral/Learning Problems	Other Diagnosis
			Yes	No	Yes	No		
			☐	☐	☐	☐		
			☐	☐	☐	☐		
			☐	☐	☐	☐		

If more space is needed, please use "Additional Information" on page 7

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Biological Family History

Birth Mother: _____

Birthdate: _____ Phone: _____ Cell: _____

At time of Client's birth:

Age: _____ Marital Status _____

Living Situation/Accommodations_____

History of: Learning/Employment Difficulties: _____

Birth Father: _____

Birthdate: _____ Phone: _____ Cell: _____

History of: Learning/Employment Difficulties: _____

Substance Use History

Describe birth mother's life 1 year before client was born: _____

Describe birth mother's social life at the time of the pregnancy:_____

Did the birth mother have any chronic illnesses, mental health related concerns, and stress related circumstances during the pregnancy? If so, please describe

_____

_____

What part of her pregnancy was the alcohol consumed? 1st trimester _____ 2nd trimester_____ 3rd trimester_____

How many alcoholic drinks were consumed throughout the pregnancy? 4-9 drinks 10+ drinks

How often was alcohol consumed throughout the pregnancy? Daily Weekly Monthly

What types of alcohol (beer, wine, coolers, and liquor) did birth mother consume during pregnancy? _____

What types of and how often were solvents, if any, did birth mother drink during pregnancy. Solvents are things like mouthwash or cleaning supplies that contain alcohol._____

Did the birth mother use drugs during the pregnancy?

- Stimulants (Cocaine, Crack, Ecstasy, Meth, etc) _____
- Opiates (Fentanyl, Heroin, Oxycodone, Methamphetamines) _____
- Marijuana, Hallucinogens _____
- Prescription Medication (Pain Killers, Antipsychotics, Anticonvulsants, etc) _____

During which part of the pregnancy? 1st trimester _ _ 2nd trimester _ _ 3rd trimester _ _

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Did the birth mother smoke cigarettes during the pregnancy? Yes ☐ No ☐

How many cigarettes per day? _____

During which part of her pregnancy? 1st trimester _____ 2nd trimester _____ 3rd trimester _____

Source of this information (full name, relationship to the client, contact info)

_____

Present Situation

Please describe history of contact with birth parents, siblings, maternal extended family and paternal extended family:

_____

_____

List all the persons living in the client's current home and their relationship.

Name	Age	Relationship to Client

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Any Other Additional Information that may be helpful for us to know.

I, _____, understand that sharing personal and confidential information with NWC FASD Network will be necessary to facilitate my application and request for an FASD assessment.

I understand why I have been asked to disclose identifying health information, and I am aware of the risks and/or benefits of consenting or refusing this consent.

I understand that this information will be forwarded to the diagnostic team including but not limited to (clinic coordinator, physician and psychologist) I understand that the data may be entered anonymously for statistics keeping and research. I understand that I may revoke this consent in writing at any time.

A photocopy or facsimile of this consent shall be valid as the original.

_____ _____

Signature of Client Date

_____ _____

Witness Date

_____ _____

Signature of Guardian (If applicable) Date