Shkagamik-Kwe
HEALTH CENTRE

SHKAGAMIK-KWE HEALTH CENTRE FASD CLINIC

REFERRAL FORM

1. Referral Source **Date of Referral: _____**

Name: _____

Agency: _____

Telephone: _____Email: _____

If other than the legal guardian, is the legal guardian in agreement with this referral? Y ☐ N ☐

2. Child/Youth Information

Name: _____ Male ☐ Female ☐ Other ☐

Date of Birth: _____ OHIP #: _____

Address: _____

Telephone: _____

Band Name: _____ Band #: _____

Does the child/youth/family require the services of an interpreter? Y ☐ N ☐

If yes, specify language spoken: _____

3. Caregiver Information

Name of Primary Caregiver(s): _____

Custody Status (e.g., sole custody, joint custody): _____

Relationship to Child/Youth:

Birth Parent ☐ Adoptive Parent ☐ Alternative Care Parent ☐ Customary Care Parent ☐ Kinship

☐ Other _____

Caregiver Address (if different from above) _____

_____ Email: _____

Cell Phone:_____ Home Phone: _____

4. Legal Guardianship (if different than above)

Name of Legal Guardian(s): _____

Name of Agency: _____

Primary Worker: _____ Phone #: _____

Address: _____

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5. Daycare/School/ Birth Hospital Information

Name of daycare: _____

Name of school: _____Grade: _____

Name and Location of Birth Hospital: _____

6. Reason for Referral/Presenting Concerns

☐ Eating Issues	☐Movement/Coordination	☐ Mental Health
☐ Sleep Issues	☐ Attention	☐ Substance abuse
☐ Communication/Language	☐ Transitions	☐ Trouble with the law
☐ Self-Care/Hygiene	☐ Attendance at school/work	☐ Memory
☐ Cognition/Intellectual	☐ Learning	☐ Emotional Regulation
☐ Social Skills	☐ Behaviour	☐Other:

_____

_____

_____

7. Confirmation of Prenatal Alcohol Exposure

Yes ☐ No ☐ Suspected ☐ Unknown ☐

Please Note: *prenatal alcohol exposure must be confirmed before the child/youth can be eligible for assessment. If prenatal alcohol exposure is suspected, the referral will be on hold until confirmation is obtained. SKHC FASD Clinic staff can help guide the referrer/guardian through this process.*

8. Previous Assessments

☐ Psychology	☐ Vision	☐ Educational
☐ Psychiatry	☐ Speech/Language	☐ Genetics
☐ Hearing	☐ OT/PT	☐ Other

9. Other Agency Involvement

Please list other services/agencies (and contact person) currently involved with this family.

_____

_____

_____

_____