INTERVENTION / SUPPORT REQUEST FORM
New Brunswick Fetal Alcohol Spectrum Disorder (FASD) Centre of Excellence

Name :
DOB:
Medicare # :

Date received: _____
yyyy-mm-dd

Child/Youth/Adult Information

Name of the person who is being referred: _____ □ Female □ Male

Address (if different from the legal guardian): _____

Town / City: _____ Postal Code: _____

Telephone: _____

Date of Birth: Month_____ Day____ Year_____ Age: _____

Medicare #: _____ Expiration date: _____

Name of legal guardian (if applicable): _____

Relationship to the referred person: _____

Address: _____

Town/City: _____ Postal Code: _____

Telephone/Contact #'s: _____ Cellular: _____

Email: _____

Preferred language: _____ French _____ English _____ other _____

1. Has your child been diagnosed with FASD? ____ Yes ____ No

   If yes, by whom? _____

INTERVENTION / SUPPORT REQUEST FORM
New Brunswick Fetal Alcohol Spectrum Disorder (FASD) Centre of Excellence

Name :
DOB:
Medicare # :

2. Did he/she receive a list of recommendations with the FASD diagnosis? ____ Yes ____ No

   If yes, could you please provide a copy with this request form?

3. Does your child have other diagnoses and/or significant medical issues?

_____
_____
_____

4. Has your child been assessed by:

	Name	Date of Assessments
Psychologist		
Occupational Therapist		
Speech and Language Pathologist		

5. What type of services/ support/ education are you requesting at this time?

_____
_____
_____
_____

6. Are there supports in place for your child at school?

_____
_____
_____
_____

7. Are there supports in place for your child outside of school? E.g.: Community agencies, financial, etc.

_____
_____
_____
_____

INTERVENTION / SUPPORT REQUEST FORM
New Brunswick Fetal Alcohol Spectrum Disorder (FASD) Centre of Excellence

Name :
DOB:
Medicare # :

8. What is your Child's current living situation?

_____
_____
_____

9. Please list your child's strengths:

_____
_____
_____
_____

10. Please list your child's challenges:

_____
_____
_____
_____

11. In order for us to better serve you and your child, please answer the following question

Behavior or learning difficulties	Yes	No
Acts too young for his / her age?		
Cannot concentrate / poor attention		
Cannot follow direction or rules at home or at school		
No guilt after misbehaving		
Impulsive / acts without thinking		
Lying at home and outside the home		
Lack of focus		
Organizational difficulties		
Difficulty with task initiation		
Difficulty with transition		
Speech and Language difficulties		
Learning difficulties		
Sleep difficulties		
Difficulty with coordination / Motor skills		
Poor social skills		

INTERVENTION / SUPPORT REQUEST FORM
New Brunswick Fetal Alcohol Spectrum Disorder (FASD) Centre of Excellence

Name :
DOB:
Medicare # :

Please complete consent A or B

A. I agree that my child be referred to the NB Fetal Alcohol Spectrum Disorder (FASD) Center of Excellence for intervention and support.

_____ _____
Parent/Legal Guardian signature Date (MM/DD/YY)

B. I agree to be referred to the NB Fetal Alcohol Spectrum Disorder (FASD) Center of Excellence for intervention and support.

_____ _____
Client 16 years of age or older Signature Date (MM/DD/YY)

Please submit to the following address:

NB FASD Centre of Excellence
Vitalité Health Network
667 Champlain Street, Suite 105A
Dieppe, NB E1A 1P6
Tel: 506-862-3783 • Fax: 506-869-2147

For confidentiality reasons, always use a fax cover page