RÉSEAU DE SANTÉ vitalité HEALTH NETWORK

Centre Excellence NB FASD TSAF

REFERRAL FORM
New Brunswick Fetal Alcohol Spectrum Disorder (FASD) Centre of Excellence

Name :
DOB:
Medicare # :

Date received: _____
yyyy-mm-dd

Child / Adolescent Information

Child's name: _____ ❑ Female ❑ Male

Date of birth: Year_____ Month_____ Day_____ Age: _____

Medicare #: _____ Expiration date: _____

Referral Source

Name of person making the referral: _____

Agency: _____

Relationship to the child: _____

Contact number where you can be reached: _____

Are you a self-referral? ❑ Yes ❑ No

Family Information

Legal guardian's name: _____

Is the child adopted? ❑ Yes ❑ No

If yes: name of child before adoption (if different):_____

Address of the legal guardian: _____

City: _____ Postal code: _____

Telephone (h) _____ (w) _____ (cell) _____

Adoptive mother's date of birth: _____

Adoptive Father's date of birth: _____

Birth mother's name (if known): _____

Birth father's name (if known): _____

Foster parent's name: _____

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1. **Why are you requesting an evaluation at this time?**

_____

_____

_____

_____

2. **Are there any specific issues that lead you to believe that the child has FASD?**

_____

_____

_____

_____

3. **What previous assessments has the child been through?** (e.g. school, psychological, speech and language, mental health, judicial)

Type of Assessment	Name of Professional Who Did the Assessment	Date of Assessment

4. **Other professional agencies involved with the family:**

_____

_____

_____

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5. Are you aware of any pre-natal substance exposure for this client?

Alcohol: ❑ Confirmed **Drugs** (prescribed or other): ❑ Confirmed
❑ Suspected ❑ Suspected

6. Please describe as much detail as possible with the prenatal alcohol consumption that occurred (***quantity*** of alcohol per occasion, ***type*** of alcohol, ***time*** of alcohol consumption during pregnancy)

_____

_____

_____

_____

7. Please check the behavioral and/or learning difficulties that concern you?

Behaviour or learning difficulties	**Yes**	**No**
Acts too young for his or her age?		
Cannot concentrate / poor attention		
Cannot follow directions 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		

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Name :
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Medicare # :

Please complete consent A or B

A. I agree to my child being referred to the NB Fetal Alcohol Spectrum Disorder (FASD) Centre of Excellence for multidisciplinary team evaluation in Moncton, NB.

_____ _____
Parent / Legal Guardian signature Date (yyyy-mm-dd)

B. I agree to be referred to the NB Fetal Alcohol Spectrum Disorder (FASD) Centre of Excellence for multidisciplinary team evaluation in Moncton, NB.

_____ _____
Client 16 years of age or older Signature Date (yyyy-mm-dd)

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