NL Health Services

FASD Multidisciplinary Diagnostic Clinic Referral Form – CHILD & YOUTH (8-18 years)

Date of Referral:	
Name of Referral Source:	Agency/Organization *(if applicable)*:
Address *(Street and P.O. Box if applicable)*:	City:
Postal Code:	Telephone:
Email:	Relationship to Individual being Referred
If you are not the parent/guardian of the child/youth, is the parent/guardian aware that this referral is being made for the child/youth? ❑ Yes ❑ No	

Full **Legal Name** of the Child/Youth being Referred:	
Age:	Date of Birth:
Place of Birth:	Healthcare Number (E.g. MCP):
Address *(Street and P.O. Box if applicable)*:	
City:	Postal Code:
Telephone:	Email:

Birth Mother's Name:	Birth Mother's Date of Birth:
Birth Father's Name:	
Caregiver's Name *(if applicable)*:	

Why is assessment being requested at this time?

What indicators are there that the child/youth may be FASD affected (E.g. behaviour or learning problems)?
For more information about FASD signs and symptoms, visit CanFASD, Canadian FASD Research Network at https://canfasd.ca/fasd-faqs/.

Is prenatal alcohol exposure suspected/confirmed?
Suspected/confirmed alcohol use must be indicated. If an individual was not exposed to alcohol before birth, they are not at risk of FASD.

❑ Yes ❑ No

Additional Information *(optional)*:

Name of Individual Completing Referral *(Please Print)*

Date

Signature

Completed referral forms can be sent by mail to:

Fetal Alcohol Spectrum Disorder (FASD) Services
Mental Health & Addictions
Curtis Memorial Hospital
178-200 West Street
St. Anthony, NL A0K 4S0

Or, by email to lgzfasd@lghealth.ca.

Please Note: If communicating and/or submitting documentation via email, it is the responsibility of the sender to ensure that appropriate safeguards are used to protect personal information.

If you have questions, please contact the Regional FASD Coordinator at (709) 693-5015.

To be completed by FASD Coordinator:

Date Referral Received: _____