Fetal Alcohol Spectrum Disorder
Assessment & Diagnostic Clinic

Client: _____ **Date: _____**

A. REFERRAL INFORMATION		
1. Referral Agency:		
2. Contact Name:	Phone: Email:	Fax #:

B. CONSENT		
1. Individual Aware of Referral: ❑ YES ❑ NO		
Targeted Individual:		
Surname:	Given:	Middle:
Preferred:	Age:	DOB:
Is there an FASD diagnosis? ❑ YES ❑ NO	Who made the diagnosis?	
When?	Where?	
Is there a copy of the assessment report and if so, where can it be located?		
Is the client involved with other community resources?		

C. CAREGIVER INFORMATION		
Caregiver still involved? ❑ YES ❑ NO		
Name:	Relationship to individual:	
Address:	Phone: Cell:	Work: Email:
Name of Legal Guardian:	Phone: Cell:	Work: Email:
Birth Mother's Name: Address:	DOB:	Phone:
Birth Father's Name: Address:	DOB:	Phone:
Family Support/Advocate:		Phone:
Family Aboriginal Status: Non-aboriginal Aboriginal Status Non-status Métis Other		

D. EXPECTATIONS

1. Please explain the reason you are requesting an assessment.

   _____
   _____
   _____
   _____
   _____

2. Have you talked about this referral with the legal guardian?

   _____
   _____

3. What do you know about the referred client that may suggest they have FASD (eg. behaviours or learning challenges)?

   _____
   _____
   _____
   _____
   _____

4. What previous assessments have been done? For example: Ages & Stages Questionnaire, school, mental health, judicial, psychological, speech & language, etc.

Type of Assessment	Name of Assessor	Date of Assessment	Copies of Report YES NO

5. Is there documented confirmation of maternal drinking? From what source?

   _____
   _____
   _____

6. Please provide location of client's birth/hospital (if known).

   _____

7. Is there a caregiver/advocate that can attend with the client at the time of assessment? Please provide their name.

   _____
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   _____
   _____