Fetal Alcohol Spectrum Disorder
Assessment & Diagnostic Clinic

Client: ______________________ **Date: ______________________**

Send NCIF ❑ **YES** ❑ **NO**

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

Comments: