Lethbridge Family Services
Since 1910
DaCapo Disability Services

Fetal Alcohol Spectrum Disorder (FASD)
Assessment & Diagnostic Services

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:
Phone: Email:	Address:	
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?		
Does the client attend school/ involved with community resources? List school/resources:		

C. CAREGIVER INFORMATION		
Caregiver still involved? ❑ YES ❑ NO	****If No, skip to Birth Mother/Father Information****	
Name:	Relationship to individual:	
Address:	Phone: Cell:	Work: Email:
Name of legal guardian:	Phone: Cell:	Work: Email:
Birth Mother's Name: Current Address:	DOB:	Phone:
Birth Father's Name: Current Address:	DOB:	Phone:
Family Support/Advocate:		Phone:

Family Aboriginal Status:
Non-aboriginal Aboriginal Status Non-status Métis Other

D. EXPECTATIONS

1. Explain the reason you are requesting an assessment.

2. Have you talked about this referral with the legal guardian (if applicable)?

3. Why is it suspected the client may have FASD (e.g., 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 prenatal alcohol exposure? From what source?

6. Please provide the name of the hospital and the location where the client was born.

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