FASD Consultant Referral Form

Please send referral to Contact Hamilton Children and Youth Services
Fax 905-522-5998 Email info@contacthamilton.ca
Complete all portions of the referral

☐ I have consent of the parent/guardian/youth (mandatory if over 16) to make this referral
☐ The client prefers services provided in French

Referral Completed By

Name _____ Date_____

Agency _____ Phone number _____

Email _____

Client/Family Information

Child/Youth's Name _____ Date of Birth _____Age _____

Address _____

FASD is ☐ Suspected ☐ Diagnosed If diagnosed, by whom?_____

Other Diagnosis? _____

Has a psychological assessment been completed? ☐ Yes ☐ No (If Yes, please attach)

Language Spoken _____ Interpreter needed? ☐ Yes ☐ No

Indigenous Heritage ☐ Yes ☐ No

School/School Board _____

Child/Youth Primary Contact _____Phone number _____

Email _____ Contact by Phone ☐ Email ☐

Relationship to client _____

What does the Child/Youth/Family need from the FASD program?

☐ Information and Resources about FASD

☐ Resource Planning or Community Case Conference

☐ FASD training for supports involved with the Child/Youth/Family

☐ Brief Coordination of Services

Specialized Services Involved and Contact Information (if available)

☐ Medical (List)

_____

☐ Mental Health (List)

_____

☐ Developmental services (List)

_____

☐ Respite supports (List)

_____

☐ Funding (List)

_____

☐ Other (List)

_____

Thank you!

A member of our team will contact you to discuss this referral