McMaster Children's Hospital
HAMILTON HEALTH SCIENCES

De dwa da dehs nye>s Aboriginal Health Centre
FASD Diagnostic and Assessment Service

678 Main St E, Hamilton ON, L8M 1K3
Phone: 905-544-4320
Fax: 905-544-4247

36 King St, Brantford, ON N3T NC5
Phone: 519-752-4340
Fax: 519-752-6096

www.aboriginalhealthcentre.ca

Referral Form – Community/Self-Referral

Date of Request	YY/MM/DD	**Girl ☐ Boy ☐**	**Healthcard #:**	VERSION CODE	
Child/Youth's Name:	LAST NAME	FIRST NAME		**Date of Birth:**	YY/MM/DD
Address:		**City:**		**Postal Code:**	
Secondary Address:		**City:**		**Postal Code:**	

Do you identify as Indigenous?
☐ **Status** ☐**Non-Status** ☐**Metis** ☐**Inuit** ☐**Non-Indigenous** ☐**Other**

Name of parent/guardian (or foster/adoptive/step parent):
Home Phone: **Cell Phone:** **Email:**

Name of parent/guardian (or foster/adoptive/step parent):
Home phone: **Cell phone:** **Email:**

What is the best way/time to reach the parent(s) or legal guardian?

Is an interpreter required? If 'yes', language spoken:

Reason for Referral: (Please describe your concerns. E.g. behavior concerns, attention, school, sleeping, impulse control, violence etc. Include any relevant documentation.)

Are you aware of any alcohol exposure in pregnancy?: ☐**Yes** ☐**No** ☐**Unknown**

Is the child/youth receiving any other services at the Ron Joyce Children's Health Centre (e.g. SLP, SW, OT, PT):

Is the child/youth involved with any other professionals/services (e.g. CAS/CCAS, Early Words):

Does the child/youth have any other relevant diagnoses or conditions, allergies, medications?

Do you have any relevant medical/psychiatric/safety concerns regarding the child, youth or family?:

Name of Family Doctor or Nurse Practitioner:
Phone:
Fax:

Additional Comments:

Name of person completing this form:		**Signature:**	
Relationship to Child/Youth:			
Phone:		**Email:**	**Fax:**