

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

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## www.aboriginalhealthcentre.ca

Referral Form - Community/Self-Referral

Date of Request    VIMMUDD   Girl   Boy   Healthcard #:   VERSION CODE   Child/Youth's   Name:   PRST NAME   PRST NAME   Date of Birth:   WIRMUDD							ility/ Sell-Re						
Name:    STAMME   STA	-		YY/MM/D	YY/MM/DD <b>Girl</b>		Boy 🗌	Healthcard #:			VERSION CODE			
Address:    City:   Code:	_	•	LAST NAME			NAME				YY/MM/DD			
Address: ' City: Code:  Do you identify as Indigenous?   Status   Non-Status   Metis   Inuit   Non-Indigenous   Other    Name of parent/guardian (or foster/adoptive/step parent):   Email:  Name of parent/guardian (or foster/adoptive/step parent):   Email:    Name of parent/guardian (or foster/adoptive/step parent):   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:   Signature:   Relationship to Child/Youth:	Address:						City:			Code:			
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