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
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www.aboriginalhealthcentre.ca

Referral Form - Professional

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 the concerns for this client. E.g. behavior concerns, attention, school, sleeping, impulse control, violence etc. Include any relevant documentation.)

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):

Other professionals/services currently involved (e.g. CAS/CCAS, Early Words):

Other relevant diagnoses or conditions, allergies, medications:

Relevant medical/psychiatric/safety concerns regarding the family:

Family Doctor or Nurse Practitioner: **Phone:**

Additional Comments:

Referral source name & address:		**Signature:**	
Phone:		**Email:**	**Fax:**

If applicable: Physician's OHIP Billing Number: **Physician's Signature:**

OHIP regulations stipulate that requests for physician consultations must be provided in writing by a physician.