

General Information Form

Manitoba FASD Centre. Rehabilitation Centre for Children
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MANITOBA

FASD CENTRE

•Assessment •Education •Training •Research

Child/Youth's Name: _____	Date of Birth: ___/___/___ d/m/y
Age: _____ <input type="checkbox"/> Female <input type="checkbox"/> Male	Health Care #: _____ PHIN#: _____
Name of Primary Caregiver: _____	
Relationship to Child/Youth: <input type="checkbox"/> Birth <input type="checkbox"/> Adoptive <input type="checkbox"/> Foster <input type="checkbox"/> Other _____	
Caregiver's Address: _____	City: _____
Postal Code: _____	Home Phone: _____ Work Phone: _____
Who is requesting the assessment at the Manitoba FASD Centre? _____	
If other than legal guardian, has this request been discussed with the legal guardian? <input type="checkbox"/> Yes <input type="checkbox"/> No	

What are the desired outcomes of the assessment? _____

Describe the child or youth's current difficulties and how long they have been occurring. _____

What are the child/youth's strengths? _____

Has the child/youth been previously assessed for FASD? Yes No Unknown
If yes, diagnosis: _____ Who made the diagnosis? _____

Has the child/youth been seen at:
Child Development Clinic: Yes No Unknown If yes, when _____
Genetics: Yes No Unknown If yes, when _____

FAMILY HISTORY

Birth Mother's Name: _____

Date of Birth: ____/____/____ d/m/y

Address: _____

Birth Father's Name: _____

Date of Birth: ____/____/____ d/m/y

Address: _____

Child/Youth's Brother(s) and/or Sister(s)			
NAME	Male/Female	Date of Birth (d/m/y)	Full or Half Sibling

Current Household Members: *(if siblings are also in this household, please circle their names above and their information does not need to be repeated below)*

NAME	Relationship to Child	Date of Birth (d/m/y)

Has anyone in this **child/youth's biological family** ever had any of the following conditions? *Please check all that apply.*

	Birth Mother	Birth Father	Mother's Family	Father's Family	Siblings of child
Learning Disability/Problems	_____	_____	_____	_____	_____
Developmental Delays	_____	_____	_____	_____	_____
Attention Deficit/Hyperactivity	_____	_____	_____	_____	_____
Depression	_____	_____	_____	_____	_____
Mental Illness	_____	_____	_____	_____	_____
Chronic Illness	_____	_____	_____	_____	_____
Emotional Problems	_____	_____	_____	_____	_____
Speech & Language Delays	_____	_____	_____	_____	_____
Birth Defects (cleft lip/palate, heart problems from birth)	_____	_____	_____	_____	_____
Specific Genetic Syndrome	_____	_____	_____	_____	_____
Others	_____	_____	_____	_____	_____
Additional Information (Optional): _____					

FETAL ALCOHOL EXPOSURE HISTORY

In order for an assessment for FASD to occur, there needs to be prenatal alcohol exposure information. If the prenatal alcohol history is suspected and/or not available, please contact social work staff at the FASD Centre [(204) 235-8866] to discuss how to proceed with this referral.

Was alcohol used in the pregnancy? Yes No Suspected Unknown

First Trimester (1 to 3 months) Yes No Suspected Unknown

Second Trimester (4 to 6 months) Yes No Suspected Unknown

Third Trimester (7 to 9 months) Yes No Suspected Unknown

Average number of drinks per drinking occasion: _____ Maximum number of drinks per occasion: _____

Number of drinking occasions per week: _____

Who is the source of this information? _____

If available, please provide additional information regarding the prenatal alcohol use and/or pregnancy.

If alcohol use is suspected but not known for sure, please describe reason for concern.

Other exposures during this pregnancy:

Marijuana Yes No Trimester _____

Cocaine Yes No Trimester _____

Solvents Yes No Trimester _____

Prescription Drugs Yes No Trimester _____

Tobacco Yes No Trimester _____

X-rays Yes No Trimester _____

Other, please specify _____ Trimester _____

Have any siblings of this child/youth been diagnosed with FASD? Yes No Unknown

BIRTH HISTORY OF CHILD/YOUTH

Birth Hospital: _____ Address: _____

Was the child/youth born with, or later discovered to have any birth defects (e.g., cleft lip & palate, heart disease,)? Yes No Unknown

If yes, specify: _____

Was the child/youth premature? Yes No Unknown If yes, by how many week/months? _____

Did the child/youth have any of the following problems in the hospital? Feeding Apnea/breathing Jaundice Infection

MEDICAL HISTORY

Does the child/youth have any history of the following? If yes, please specify.

- Chronic Illnesses: Yes No Unknown Explain:_____
- Hearing Concerns: Yes No Unknown Explain:_____
- Vision Concerns: Yes No Unknown Explain:_____
- Hospitalizations: Yes No Unknown Explain:_____
- History or Seizures: Yes No Unknown Explain:_____
- Serious Accidents: Yes No Unknown Explain:_____

Is the child/youth currently on medication? Yes No Unknown If yes, please list (e.g., Ritalin, Risperidone): _____

DEVELOPMENTAL HISTORY (if available)

When did your **child/youth**.....

- | | | | |
|------------------------------|----------|-------------------------------|----------|
| Sit with support | Age_____ | Dress self | Age_____ |
| Crawl | Age_____ | Use zippers/buttons | Age_____ |
| Walk alone | Age_____ | Wash hands? | Age_____ |
| Walk up stairs | Age_____ | Become toilet trained (day) | Age_____ |
| Ride a tricycle using pedals | Age_____ | Become toilet trained (night) | Age_____ |
| Use fingers to feed | Age_____ | Say his/her first word | Age_____ |
| Use a spoon | Age_____ | Put 2 words together | Age_____ |
| Feed self | Age_____ | Use 3 to 4 word sentences | Age_____ |
| Undress self | Age_____ | | |

What percentage of language spoken in home is English? _____

Other languages spoken in the home? _____

Have you ever been worried about the child's development? Yes No Unknown

Has the child/youth ever had trouble with any of the following:

- Gross motor skills (use of large muscles for running, walking, climbing)
- Fine motor skills (use of hands, pencil skills)
- Language skills
- Self-control skills (impulse control, hyperactivity, attention span)
- Self-concept (child/youth's opinion about their appearance or abilities)
- Bedwetting or soiling
- Social skills (getting along with other children)
- Growth (Have you been concerned about your child/youth's growth?)
- Feeding (drinking, chewing or swallowing food)
- Sensory processing (reactions to noises, lights, touch, movement, tastes, smells)
- Sleeping (settling for sleep, sleeping through the night)

If you answered yes to any of the above, please describe: _____

DAYCARE / PRESCHOOL INFORMATION

Is your child attending daycare? Yes No If yes, name of daycare: _____

Does your child/youth get extra help at daycare? Yes No

SCHOOL INFORMATION

Is your child/youth attending school? Yes No If yes, name of school: _____

School Division: _____

Is your child/youth having difficulty in school or daycare with *(check all that apply)*

- learning behaviour getting along with peers sitting on the school bus
- during lunch hour during recess in gym/music class before/after school

Does your child/youth get extra help at school from *(check all that apply)*

- level II funded level III funded educational assistant resource time other _____

Has your child/youth ever been suspended from school? Yes No If yes, for what reason(s) _____

(Please note: Further information from the school or daycare will be obtained through additional questionnaires.)

CHILD/YOUTH AND PARENTING INFORMATION

What are your child/youth's favourite activities? Least favourite? _____

Please describe your child/youth's behaviour, including any behaviours that may be challenging: _____

What disciplinary techniques or limit setting do you usually use with your child/youth? *Place a check next to each technique that you may use.*

- Ignore problem behaviour Reason with child/youth Tell child/youth to sit on chair
- Redirect child/youth's interest Scold child/youth Spank child
- Take away some activity or food Ground child/youth (For how long? _____) Send child/youth to his/her room
- Time-outs (For how long? _____) Threaten child Don't use any technique

[Optional] Please provide additional information _____

Are you concerned about your child/youth using substances? Yes No If yes, which: Alcohol Solvents/sniffing Drugs

[Optional] Please provide additional information _____

ADDITIONAL FAMILY INFORMATION:

Has your child/youth experienced or witnessed any of the following: *[This can be left blank if child is in CFS care as similar history gathered in a Social History Form]*

- Upsetting losses or changes
- Family conflict/family stress
- Extended separations from mother and/or father or primary caregiver
- Other potentially stressful, upsetting and/or traumatic events

Please provide details if possible *(attach additional pages if needed)* _____

If the child/youth is in care of Child and Family Services, please complete the following:

Name of Authority: _____

Name of Agency: _____

Address: _____ Postal Code: _____

Name of Worker: _____

Phone: _____ Fax _____ Email: _____

Is the child/youth: Temporary Ward Permanent Ward Under a Voluntary Placement Agreement

Is the birth family visiting with the child/youth? Yes No

Is reunification with birth family planned? Yes No

Is the birth mother aware of this referral? Yes No Unknown

Is the birth mother in agreement with this referral? Yes No Unknown

PERSON FILLING OUT THIS FORM

Name of person completing this form: _____

Relationship to the child/youth (or family): _____

Phone: _____ Address: _____
(include postal code)

Name of person providing the information *(if different from above)*: _____

Relationship to the child/youth (or family): _____

Phone: _____ Address: _____
(include postal code)

DATE COMPLETED _____