

Referral Form

Manitoba FASD Centre. Rehabilitation Centre for Children
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. www.fasdmanitoba.com
Phone: (204) 235-8866. fax: (204) 235-8870



MANITOBA
FASD CENTRE
• Assessment • Education • Training • Research •

Date of referral: _____ Source of Referral: _____

Child/Youth's Name: _____ Date of Birth: ___/___/___ d/m/y

Name of Caregiver: _____

Relationship to Child/Youth: Birth Adoptive Foster Other _____

Caregiver's Address: _____ City: _____

Postal Code: _____ Home Phone: _____ Work Phone: _____

Child/youth's physician: _____

Who is requesting this FASD assessment? _____

Is the child/youth's legal guardian in agreement with this referral? Yes No Unknown

If child/youth is 12 years of age or over, is he/she aware of this referral? Yes No Unknown

If no, would you like information on how to discuss this with him/her? Yes No Unknown

If the child/youth is in the care of a child welfare agency, please complete:

Name of Worker: _____ Phone: _____

Agency: _____ Fax: _____

Address: _____ Email: _____

Is the child/youth in under a:

Permanent order Temporary order Voluntary placement agreement Voluntary surrender of guardianship

Other _____

Is the birth mother involved with the care of this child/youth? Yes No Is she aware of this referral? Yes No

PRESENTING PROBLEM

Briefly describe the child/youth's current difficulties. _____

Has the child/youth received evaluation or treatment for the current problem or similar problem? Yes No

If yes, when and with whom? _____

Is the child/youth on any medication at this time? Yes No

If yes, list medications _____

What are the child/youth's strengths? _____

Is the child in Daycare? Yes No If yes, name of Daycare _____

Is the child/youth in school? Yes No If yes, name of School _____ Grade _____

School Contact Person [if known] _____

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.

Is the prenatal alcohol exposure confirmed? Yes No Who is the source of this information? _____

Please provide information regarding prenatal alcohol exposure in this pregnancy [if available]. _____

Please provide information regarding other substance(s) which the child/youth may have been exposed to.

Tobacco Solvent/Inhalant Marijuana Caffeine Talwin & Ritalin Cocaine Crystal Meth

Other: _____

Name of person completing this form: _____

Relationship to child/youth referred: _____

Address [if not provided above]: _____ Phone: _____

Signature: _____ Date: _____