Denisiqi Services Society

FASD Worker Referral Form

- ○ PRESCREENING
- ○ EDUCATION/WORKSHOPS
- ○ UNDERSTANDING BEHAVIOUR PROBLEMS
- ○ LEARNING DISORDERS
- ○ 1-1 SUPPORTS
- ○ SOCIAL/EMOTIONAL SUPPORTS
- ○ IHCAN ASSESMENT APPLICATION SUPPORT
- ○ OTHER:_____

Individual Referred

Last Name	First Name	Initial	Age *(please not if actual age differs from cognitive age*):

Date of Birth:	Gender:
Address (including postal code):	Client Home/ Cell Phone:
	School Name: Grade:

Status: Yes □ No □ Metis: Yes □ No □	Urban □ Rural □	Affiliated Band:

Name of Parent(s)/Legal Guardian(s)/Caregiver(s):

Name: _____ Home/Cell Phone: _____ **Email:** _____
Name: _____ Home/Cell Phone: _____ **Email:** _____
Name: _____ Home/Cell Phone: _____ **Email:** _____

Has child/youth had a psychological assessment? Yes □ No □
If yes, when/with who?

Family Doctor's Name:

Current Medications:

What are your child's strengths?

Is there anything else we should know about your child? *(Ex: likes/dislikes)*

Was there alcohol exposure during pregnancy? Yes □ No □ Not Sure □	Is client aware of this referral? Yes □ No □ Urgent? Yes □ No □

Referral Source

Referral Date:	Referral Source/Agency (if any):
Referral Source Name (Print):	Referral Source Email:

Please return to DSS Attn. FASD Worker Fax: 250-392-6501 Thank-you!