Referral Form

MANITOBA FASD NETWORK
Professional FASD Assessment and Support

SSCY Centre
Specialized Services for Children & Youth
Together Is Better

Date of Referral: _____

Located at: SSCY Centre
1155 Notre Dame Ave
Winnipeg, MB R3E EG1
Ph: (204) 258-6600
Fax: (204) 258-6797
www.fasdmanitoba.com

Person Completing Referral:

☐ Caregiver ☐ CFS ☐ Physician ☐ School ☐ Community ☐ Allied Professional ☐ Other _____

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

MHSC #: _____ PHIN#: _____ Gender: ☐ Female ☐ Male

Name of Caregiver: _____

Relationship to Child/Youth ☐ Birth ☐ Adoptive ☐ Foster ☐ Other

Caregiver's Address: _____ City: _____

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

Who is the doctor providing medical care to the child/youth? _____

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

Name of worker: _____ Phone: _____

Agency: _____ Fax: _____

Email: _____

CFS Authority: ☐ Northern ☐ Southern ☐ General ☐ Mètis

Reason for 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]

Additional Information
Is your child currently attending day care or school?
If yes, please provide name:

Signature: _____ Print Name: _____

Telephone #: _____ Address *(incl. postal code)*: _____