

Dufferin Wellington Fetal Alcohol Spectrum Disorder Request for Service

Date of Referral / Request: (mm/dd/yyyy) | _____

Child/Youth

Child/Youth Full Name:		Date of Birth (mm/dd/yyyy)	
Street Address		Town	Province
Postal			
Parent/Legal Guardian		Relationship	Contact Number
			Alternate Number
Email Address		<input type="checkbox"/> Consent to contact you by email	
Best Day/Time to Contact		Preferred Method of Contact <input type="checkbox"/> Telephone <input type="checkbox"/> Email <input type="checkbox"/> Text	
Child or Youth lives with: <input type="checkbox"/> Both Parents (include both parent names above) OR <input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Guardian <input type="checkbox"/> Other			
Languages spoken in the home: Interpreter Required: <input type="checkbox"/> Yes or <input type="checkbox"/> No Preferred Language: _____			
Does the family identify as First Nation, Metis or Inuit? <input type="checkbox"/> Yes or <input type="checkbox"/> No If yes, provide details: _____			
Diagnosis of FASD:		<input type="checkbox"/> Suspected <input type="checkbox"/> Confirmed	Date: mm/dd/yyyy. By Whom: Click here to enter text.
Other Diagnoses:			

Referral Source		
Contact Name	Service/Agency Name	Contact Information

School			
School Name & Board	Grade	Main Contact Name	Contact Information

Other Services Involved		
Name	Service/Agency Name	Contact Information

Request for Service	
Support and Consultation	<input type="checkbox"/> Child / Youth Specific <input type="checkbox"/> Caregiver / Family
Community Capacity Building	<input type="checkbox"/> Professional Development <input type="checkbox"/> Awareness / Information
Other	<input type="checkbox"/> Case Conference <input type="checkbox"/> Training/Info Session <input type="checkbox"/> Resource Information

Additional Notes (Additional Notes: if known, estimate amount of time or length of training session).

Consent
I have consent from the legal guardian to submit this form. <input type="checkbox"/> Yes <input type="checkbox"/> No
The legal guardian gives consent for the FASD Worker Program. <input type="checkbox"/> Yes <input type="checkbox"/> No
The youth (12 -21 years old) gives consent for the FASD Worker Program. <input type="checkbox"/> Yes <input type="checkbox"/> No
I am the Parent/Legal Guardian and consent to the FASD Coordinator sharing information with Service Providers listed above. <input type="checkbox"/> Yes <input type="checkbox"/> No