Willow Winds
SUPPORT NETWORK
Site #1, Comp 8, RR 001
Canwood, SK S0J 0K0

Adult Clinic Coordinator: Jennifer P • jennp@wwsn.ca • Ph: 780-974-7112

PLEASE READ BEFORE FILLING OUT A REFERRAL FORM

The criteria REQUIRED by Willow Winds Support Network in order to do an FASD assessment are:

Confirmation of Prenatal Alcohol Exposure (PAE) MUST accompany the submission of this referral form and MUST come from one or more of the valid sources listed below:

If birth mother is alive, confirmation of PAE MUST come from her.

If the birth mother is deceased and/or cannot be located confirmation of PAE MUST be obtained from the maternal side of the family (excluding current caregiver) and/or from agency file documentation.

1. **Did birth mother consume alcohol in the amount of 7 or more drinks for seven consecutive days twice during the pregnancy? Yes _______ No ________**

2. **Did birth mother consume 4 or more drinks on at least two separate occasions during pregnancy? Yes __________ No _________**

If you did not answer yes to either of the two questions you do not meet the criteria to have an FASD Assessment done.

If you answered yes to either of the two questions and the confirmed PAE comes from one of the valid sources listed above please fill out the referral form.

Adult referrals can be emailed to jennp@wwsn.ca

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Adult Assessment & Diagnostics Services Referral Form

Date: ____________________________________

Client Information

Client Name: ____ **Male** _____ **Female** _____ **Other** _______________

Name @ Birth (if different from above): ____

Date of Birth: __________________________ **Health Care Number:** ____

Address: ____ **Postal Code:** __________________

Cell: _____________________ **Other:** _____________________

Hospital at Birth: ____

Culture Origin: First Nations _____ Metis _____ Inuit _____ Caucasian _____ African American _____ Hispanic _____ Asian _____

Other _____

On Reserve: Yes _____ No _____

Treaty #: _______________ **Band:** ______________ **Registered:** Yes _____ No _____

Current Support Mentor/Agency Involvement

Name: ____________________________________ **Agency:** ____

Phone: _________________ **Cell:** _________________ **Fax:** _________________ **E-mail:** ____________________________

Has CFS ever been involved? Yes _____ (Which Location:) __________________________________ No _____

Family Doctor: ______________________________ **Clinic/Location:** __________________________________

Phone: _________________ **Fax:** _________________

Are there any legal or pending court dates? Yes _____ No _____

If so, please provide details:

____

____

Has there been any assessments been completed to date? Yes _____ No _____

If so, attach copies or list assessments and name of the professional involved:

____

____

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Please check all areas of concern with brief explanation:

Affect Regulation and Brackets Behavior: ____

Sensory Concerns: ____

Learning Difficulties: ____

Adaptive Living Concerns: ____

Difficulties with the Law: ____

Employment/Income Support History: ____

Social Skills Difficulties: ____

Substance Abuse: ____

Suicide Attempt/Ideation: ____

Abstract Concepts (time/money): ____

Hyperactivity/Impulsivity: Yes _____ No _____

What are the client's strengths and interests?: ____

Cultural/Spiritual/Religious Activities: ____

Current Program Involvement

Name of Schools Attended: ____

Last Grade Attended: ________________

Does the client currently attend a school or training program: Yes _____ No _____ Where __________________________

Is the client currently employed: Yes _____ No _____ Where __________________________ Part-Time _____ Full-Time _____

Health History

Was the client born with (or later discovered to have) any birth defects (e.g. cleft palate, congenital heat defects, clubfoot, etc.)?

Yes _____ No _____ Unknown _____ If yes, please explain: ____

____

Has the client had any Chronic Illnesses? If yes, please explain: ____

____

Has this client had any hospitalizations and/or surgeries since birth? Yes _____ No _____ Where __________________________

____

____

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OTHER HISTORICAL HEALTH RELATED ISSUES	YES	NO
Physical Abuse		
Sexual Abuse		
Did a physician evaluate this?		
Emotional Abuse		
Neglect		
Witness to Violence		
Other		

Neurological/Mental Health History

Has this client ever had seizures? Yes _____ No _____ **Head injury leading to unconsciousness?** Yes _____ No _____

Bed-wetting or soiling after 8 years old? Yes _____ No _____ **Is this still continuing today?** Yes _____ No _____

CT or MRI scan of brain? Yes _____ No _____ If yes, where was this completed? ____________________________________

List of Current Medications/Treatments:

____

____

Pregnancies of Biological Mother (including miscarriage and abortion)

Year	Length of Pregnancy	Name of Child	Born Alive		Normally Developed		Behavioral/Learning Problems	Other Diagnosis
			Yes	No	Yes	No		

If more space is needed, please use "Additional Information" on page 7

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Biological Family History

Birth Mother: ____

Birth Date (YYYY / MM / DD): ______________________ **Phone:** ____________________ **Cell:** ____________________

At time of Client's Birth:

Age: __________ **Marital Status:** ____

Living Situation/Accommodations: ____

History of Learning/Employment Difficulties: ____

Birth Father: ____

Birth Date (YYYY / MM / DD): ______________________ **Phone:** ____________________ **Cell:** ____________________

History of Learning/Employment Difficulties: ____

Substance Use History

Describe birth mother's life 1 year before client was born: ____

Describe birth mother's social life at the time of the pregnancy: ____

Did the birth mother have any chronic illnesses, mental health related concerns, and stress related circumstances during the pregnancy? If so, please describe:

____

____

____

What part of her pregnancy was the alcohol consumed: 1st Trimester _____ 2nd Trimester _____ 3rd Trimester _____

How many alcoholic drinks were consumed throughout the pregnancy: 4-9 drinks 10+ drinks

How often was alcohol consumed throughout the pregnancy: Daily Weekly Monthly

What types of alcohol (beer, wine, coolers and liquor) did birth mother consume during pregnancy?

____

What types of and how often were solvents, if any, did birth mother drink during pregnancy?
Solvents are things like mouthwash or cleaning supplies that contain alcohol.

____

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Did the birth mother use drugs during pregnancy?

- ☐ **Stimulants** (Cocaine, Crack, Ecstasy, Meth, etc.) ____
- ☐ **Opiates** (Fentanyl, Heroin Oxycodone, Methamphetamines) ______________________
- ☐ **Marijuana, Hallucinogens** ________________________________
- ☐ **Prescription Medication** (Pain Killers, Antipsychotics, Anticonvulsants, etc.) ______________

During which part of the pregnancy?: 1st Trimester _____ 2nd Trimester _____ 3rd Trimester _____

Did the birth mother smoke cigarettes during the pregnancy: Yes _____ No _____

How many cigarettes per day? _____

During which part of the pregnancy?: 1st Trimester _____ 2nd Trimester _____ 3rd Trimester _____

Source of this Information: *(Full Name, Relationship to the Client, Contact Info)*

____

____

Present Situation

Please describe history of contact with birth parents, siblings, maternal extended family and paternal extended family:

____

____

List all the persons living in the client's current home and their relationship.

NAME	AGE	RELATIONSHIP TO CLIENT

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Any Other Additional Information that may be helpful for us to know.