



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 heart 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

