De dwa da dehs nye>s Aboriginal Health Centre
FASD Diagnostic and Assessment Service

678 Main St E, Hamilton ON, L8M 1K3
Phone: 905-544-4320
Fax: 905-544-4247

36 King St, Brantford, ON N3T NC5
Phone: 519-752-4340
Fax: 519-752-6096

www.aboriginalhealthcentre.ca

Referral Form – Community/Self-Referral

Date of Request	yy/mm/dd	**Gender:**		**Healthcard #:** Health Number & Version Code			
Child/Youth's Name:	Last Name	First Name			**Date of Birth:**	yy/mm/dd	
Address:			**City:**			**Postal Code:**	
Secondary Address:			**City:**			**Postal Code:**	

Do you identify as Indigenous?
☐ **Status** ☐ **Non-Status** ☐ **Metis** ☐ **Inuit** ☐ **Non-Indigenous** ☐ **Other**

Name of parent/guardian (or foster/adoptive/step parent):
Home Phone: **Cell Phone:** **Email:**

Name of parent/guardian (or foster/adoptive/step parent):
Home phone: **Cell phone:** **Email:**

What is the best way/time to reach the parent(s) or legal guardian?

Is an interpreter required? If 'yes', language spoken:

Reason for Referral: (Please describe your concerns. E.g. behavior concerns, attention, school, sleeping, impulse control, violence etc. Include any relevant documentation.)

Are you aware of any alcohol exposure in pregnancy?: ☐ **Yes** ☐ **No** ☐ **Unknown**

Is the child/youth receiving any other services at the Ron Joyce Children's Health Centre (e.g. SLP, SW, OT, PT):

Is the child/youth involved with any other professionals/services (e.g. CAS/CCAS, Early Words):

Does the child/youth have any other relevant diagnoses or conditions, allergies, medications?

Do you have any relevant medical/psychiatric/safety concerns regarding the child, youth or family?:

Name of Family Doctor or Nurse Practitioner:
Phone:
Fax:

Additional Comments:

(See Page 2)

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Authorization for Release of Information

I, _____ (patient or legal guardian name), authorize De dwa da dehs nye>s Aboriginal Health Centre to:

a) **Create a patient chart within our electronic medical record and,**
b) **Communicate and exchange information with McMaster Children's Hospital for the purpose of providing, coordinating and continuing care that is in my/the patients best interest. You may withdraw this consent at any time. All information will be maintained CONFIDENTIAL between all parties involved.**

Name of person completing this form:		**Signature:**			
Relationship to Child/Youth:					
Phone:		**Email:**		**Fax:**	