



# FASD Consultant Referral Form

Please send referral to Contact Hamilton Children and Youth Services  
Fax 905-522-5998 Email info@contacthamilton.ca  
Complete all portions of the referral

- I have consent of the parent/guardian/youth (mandatory if over 16) to make this referral
- The client prefers services provided in French

## Referral Completed By

Name \_\_\_\_\_ Date \_\_\_\_\_  
Agency \_\_\_\_\_ Phone number \_\_\_\_\_  
Email \_\_\_\_\_

## Client/Family Information

Child/Youth's Name \_\_\_\_\_ Date of Birth \_\_\_\_\_ Age \_\_\_\_\_  
Address \_\_\_\_\_  
FASD is  Suspected  Diagnosed If diagnosed, by whom? \_\_\_\_\_  
Other Diagnosis? \_\_\_\_\_  
Has a psychological assessment been completed?  Yes  No (If Yes, please attach)  
Language Spoken \_\_\_\_\_ Interpreter needed?  Yes  No  
Indigenous Heritage  Yes  No  
School/School Board \_\_\_\_\_  
Child/Youth Primary Contact \_\_\_\_\_ Phone number \_\_\_\_\_  
Email \_\_\_\_\_ Contact by Phone  Email   
Relationship to client \_\_\_\_\_

**What does the Child/Youth/Family need from the FASD program?**

- Information and Resources about FASD
- Resource Planning or Community Case Conference
- FASD training for supports involved with the Child/Youth/Family
- Brief Coordination of Services

**Specialized Services Involved and Contact Information (if available)**

Medical (List)

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Mental Health (List)

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Developmental services (List)

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Respite supports (List)

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Funding (List)

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Other (List)

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**Thank you!**

**A member of our team will contact you to discuss this referral**