NORTHWEST TERRITORIES
Health and Social Services Authority

ADULT FASD DIAGNOSTIC CLINIC
REFERRAL FORM

CLIENT INFORMATION	
Name:	**Date of referral:**
Date of Birth:	**Phone:**
Health Care Number:	**Home Community:**

Ethnicity:

☐ Dene ☐ Inuit ☐ Metis ☐ Indigenous Metis ☐ Non-Indigenous ☐ Other

☐ First Nation Status Card
☐ Nunavut Inuit Enrolment Card (NTI) Card Number:_____
☐ Métis Citizenship Card

REFERRAL SOURCE AND REGION

Referral Source:_____ Contact Information:_____

Region:
☐ Beaufort-Delta ☐ Dehcho ☐ Fort Smith ☐ Sahtu ☐Yellowknife ☐Hay River ☐ Tlicho ☐ STH

REASON FOR REFERRAL

SERVICE(S) REQUESTED

☐ Fetal Alcohol Spectrum Disorder Diagnostic Clinic (age 17 years and older)	☐ Community Support ☐ Consultation (home, school, community) ☐ Case management/Resource Navigation

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PRESENTING AREAS OF CONCERN	
☐ Attention difficulties	☐ Behaviors at home
☐ Learning difficulties	☐ Hyperactivity
☐ Legal/criminal involvement	☐ Impulsivity
☐ Difficulty solving problems	☐ Health concerns
☐ Speech and Language	☐ Safety concerns
☐ Emotional regulation	☐ Self-Harm
☐ Social skills	☐ Hearing/vision
☐ Adaptive skills	☐ Memory
☐ Suicidal ideation	☐ Substance use
	☐ Other:

THE CLIENT IS CURRENTLY INVOLVED WITH	
☐ Income Security	☐ Health Care (Chronic Conditions)
☐ Housing	☐ Social Services
☐ Justice	☐ Treatment/Mental Health
☐ Other:	

Are there any reason's to treat this referral with particular urgency?

☐ No ☐ Yes, explain:

☐ I have discussed the details of this referral with the Client
☐ The client has consented to this referral

Signature of Referral Source:_____ **Date:** _____

PLEASE RETURN COMPLETED FORM
TO: Adult FASD Coordinator
Email:
adultFASDprogram@gov.nt.ca

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